

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 10/7, 10/8, 10/9 and 10/17/14</p> <p>Facility number: 001100 Provider number: 15G586 AIM number: 100240050</p> <p>Surveyor: Paula Chika, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 24, 2014 by Dotty Walton, QIDP.</p>	W000000	<p><b>a)“A more frequent system is initially needed by the nurse to ensure the woundcare is done correctly.” CorrectiveAction(s): Toensure that all wound care is done correctly, the following corrective action(s)will be implemented:</b> All staff located at 1413 Darby Street (Darby grouphome) will be re-trained on proper wound care for designated client. To ensurethat all wound care is being performed as directed, the Residential Nurse willassess the wound weekly to monitor healing and to assess for changes in thecondition of the wound. Additionally, the Residential Nurse will review alldocumentation related to the wound on a weekly basis, to ensure that all woundcare is being performed and documented as directed. <b>b)“How will the positioning schedule be monitored for compliance?” CorrectiveAction(s): Toensure that the positioning schedule is monitored for compliance, the followingcorrective action(s) will be implemented:</b> The Residential House Manager will be review therepositioning tracking sheet on a daily basis to ensure that staff arerepositioning the designated client and documenting accordingly. Furthermore,the Residential Nurse will review the same</p>	
---------	---	---------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>repositioning tracking sheet on a weekly basis to further ensure compliance. Should a staff member fail to reposition Client #4 as indicated in the risk plan, he or she will be counseled per agency personnel policies and procedures. Refer to Appendix A for the repositioning tracking sheet to be used. <b>W252</b></p> <p><b>Finding(s): "The POC indicates that staff will check the positioning schedule form. Will staff routinely check the client to ensure the schedule is being implemented and that positioning and repositioning is done correctly?"</b></p> <p><b>Corrective Action(s): To ensure that positioning and repositioning is done correctly, the following corrective action(s) will be implemented:</b></p> <p>All staff located at 1413 Darby Street (Darby group home) will be retrained on Client #4's repositioning plan to ensure adequate knowledge of how to correctly position and reposition Client #4. Upon entering a scheduled shift, the incoming staff will review repositioning notes documented by staff on the prior shift to ensure proper repositioning remains consistent as staff rotate shifts. To further ensure compliance, the Residential House Manager will review the repositioning tracking sheet on a daily basis to ensure that staff are repositioning</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>the designated client and documenting accordingly. Additionally, the Residential Nurse will review the same repositioning tracking sheet on a weekly basis to further ensure compliance.</p> <p><b><u>W149/W252</u></b></p> <p><b><i>a. "What time of onsite monitoring system will be done by management staff to ensure compliance? Simply reports will not be an acceptable POC to ensure compliance."</i></b></p> <p><b>Corrective Action(s):</b></p> <p><b>To ensure staff compliance for client repositioning, the following corrective actions will be implemented:</b></p> <p>The Residential Nurse and Residential House Manager (RHM) will alternate observing direct support staff performing and completing repositioning techniques during various scheduled shifts. The Residential Nurse and Residential House Manager will each be responsible for observing repositioning by direct care staff a minimum of two times per month. The Residential Nurse and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000149	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 observation, interview and record review for 1 of 4 sampled clients (#4), the facility failed to implement its written policy and procedures to prevent neglect of a client in regard to a pressure	W000149	Residential House Manager will also be required to initial dates and shifts observed on the revised tracking sheet. Refer to Appendix A for tracking sheet to be used. If insufficiencies in level of care by staff are noted by the Nurse and/or RHM, the Director and Vice President of Residential Services will be immediately notified. Upon notification, the Director and Vice President of Residential Services will require all staff working in the home to be counseled and re-trained on agency and departmental policies and procedures. All trainings will be documented on agency Record of Training forms and retained by the Residential Services Coordinator.  <b>To ensure that established agency policies and procedures for prevention of abuse and neglect are being implemented and executed as</b>	11/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>area due to the client's wheelchair.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/8/14 at 11:36 AM. The facility's reportable incident report indicated the following:</p> <p>-9/8/14 "It was reported on 9/8/14 there was 2 very small open areas on [client #4's] thigh. The nurse came in to assess the area. [Client #4] has no fever, the area is not red, warm, or inflamed (sic) and [client #4] has not complained of pain. There is a small amount of drainage but no signs of infection or bleeding from that area. Nurse also noted the 5.2 inch surgical scar from [client #4's] surgery (biopsy on 7/15/14) intact with the exception of two small open areas. First area measures 8mm (millimeter) long and 4mm across. The second measures 4mm long and 2mm wide. In an effort to prevent infection and prevent the open area from drying out and skin breakdown, bacitracin (antibiotic ointment) is being applied to the area and covered with a 4 x (by) 4 gauze. Also, a folded towel between the area on left posterior thigh and the seat of her wheelchair, to cushion the area and prevent any type of shearing to the area</p>		<p><b>written, the following corrective action(s) will be implemented:</b></p> <p>1) Allstaff located at 1413 Darby Street (Darby group home) will be re-trained on the agency abuse and neglect policy, Prohibition of Violation of Individual Rights. Completed Record of Trainings will be obtained and submitted upon completion of training. <i>Refer to Appendix A for Record of Training form to be used.</i></p> <p>2) Allstaff located at 1413 Darby Street (Darby group home) will continue to provide wound care as previously trained. All wound care for Client #4 will be monitored by staff and the Residential Nurse will continue to provide weekly assessments of the wound to ensure proper care as instructed by the prescribing physician and to note any changes to the wound. Any changes will be noted on a Body Integrity Sheet and submitted to the Residential Nurse for review. <i>Refer to Appendix B and C for</i></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>and staff will keep the area clean and dry and to continue to monitor [client #4] for signs and symptoms of infection until [client #4] visits the plastic surgeon. [Client #4's] appointment with the plastic surgeon is scheduled for 9/12/14."</p> <p>-A 9/15/14 follow-up report indicated "1. On 9/12/14 [client #4] was seen by the plastic surgeon due to 2 new open areas on surgical wound area on left thigh. The doctor briefly looked over the open areas and stated that will heal on it's own. There has been no change in size and appearance, or new drainage since the last report. The doctor recommended to cover with gauze and to monitor it. Question asked if this may have tunneled from another area and he then put a Qtip in the open area and he determined it to be superficial. If signs of infection then to contact him for an antibiotic if needed. Doctor also encourage vitamins and good nutrition that would help the most."</p> <p>-A 9/22/14 follow-up to the 9/8/14 reportable incident report indicated client #4 had been placed on a multivitamin and vitamin C "to help with wound healing." The 9/22/14 follow-up report indicated "...Her wound care has been monitored by staff and weekly assessment by nurse to find 3 more open areas since her visit on 9/12/14. The wounds since last report</p>		<p><i>skin integrity and Record of Training forms to be used.</i></p> <p>3) AROHO cushion was ordered on October 13, 2014 for Client #4, as directed by theprescribing physician. The cushion arrived approximately on October 23, 2014and is currently in use as directed by physician orders. All staff located at1413 Darby Street (Darby group home) will continue to use the ROHO Client #4 untilotherwise stated.</p> <p>4) OnOctober 15, 2014, the reclining wheelchair as recommended by the prescribingphysician was ordered for Client #4. Asper current communications with NuMotion, two more parts are needed to completeassembly of the wheelchair. Upon assembly and completion, the wheelchair willbe delivered and provided for Client #4.</p> <p>5) Allstaff located at 1413 Darby Street (Darby group home) will be re-trained on theRepositioning Risk Plan for Client #4 to ensure proper knowledge ofrepositioning needs. The Residential House Manager and Residential</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>have reopened wider one from 8mm long and 4mm wide is now 10mm longx6mm (sic) wide. The 3 new open areas are 3mm long x 1mm wide, 1mm x 1mm wide, and 2mm x 1mm. No signs or symptoms of infection and the depth is unchanged. Physician contacted and recommended wound center and this appointment made for Sept. (September) 30."</p> <p>-A 9/30/14 follow-up to the 9/8/14 reportable incident report indicated "1. As a nursing measure [client #4] has a bandage applied to her and changed daily to keep any infection out until her visit with the wound center. 2. There have been several attempts to contact the cosmetic surgeon to release care back to the wound center before [client #4] will be seen. She was not released in time for 9/30/14 appointment. The appointment is rescheduled for 10/6/14."</p> <p>-A 10/6/14 follow-up report to the 9/8/14 reportable incident report indicated "1. From last report filed [client #4's] open areas have changed. She had 5 total areas that became 3 due to areas opened wider creating 3 open areas. Depth of an open area did not change however on she had green drainage since last report (sic). Nurse called [client #4's] general physician to order an antibiotic. [Client</p>		<p>Nurse will routinely review the repositioning tracking sheet to ensure that proper repositioning is occurring as directed in the risk plan. Should a staff member fail to reposition Client #4 as indicated in the risk plan, he or she will be counseled per agency personnel policies and procedures. <i>Refer to Appendix D for Record of Training form to be used.</i></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>#4] went to the wound center today and the doctor found no evidence of infection and much improved at this time. To continue the antibiotic prescribed by the general physician. The doctor from the wound center ordered hydrogel (wound care product) and 4x4 gauze with meplix (sic) (wound care dressing) dressing to be changed one time daily. He also ordered Roho cushion for wheelchair until chair is replaced by specialized chair. He also ordered for [client #4] to be repositioned every 2 hours (already in place). She has another visit to the wound center next Monday on 10/13/14."</p> <p>During the 10/7/14 observation period between 3:25 PM and 6:00 PM and the 10/8/14 observation period at the group home, client #4 utilized a wheelchair for her primary means of mobility. Client #4 required facility staff to push/maneuver the wheelchair. Client #4's legs/feet dangled down from the wheelchair near and/or in between the 2 footrests on the client's wheelchair. Client #4's feet were deformed and could not rest on the footrests of the wheelchair. Client #4's wheelchair was a regular wheelchair with foot rests.</p> <p>Client #4's record was reviewed on 10/8/14 at 3:40 PM. Client #4's</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>Physician's Statements (PSs) and wound clinic notes indicated the following (not all inclusive):</p> <p>-5/14/14 Client #4 went to the doctor in regard to "Wound Care." The PS indicated "Refer to [name of doctor-surgeon] for consideration for excision...."</p> <p>-6/2/14 "Initial evaluation for wound (L) (left) posterior thigh. Wound left posterior thigh Atypical in nature. Recommend Bx (biopsy) of wound."</p> <p>-9/12/14 Client #4 saw the surgeon for assessment/evaluation for an area on the client's thigh. The PS indicated the area was "Superficial on skin...." The PS indicated client #4 needed to "...continue aggressive nutritional support."</p> <p>-10/6/14 Client #4 was seen at a wound clinic for "Wound eval (evaluation) (L) posterior thigh. Subcutaneous debridement culture. Wound order Hydrogel/gauze, Mepilex tape daily after saline cleanse. Roho cushion for wheelchair-limit time to 2 hours at a time." The wound clinic's notes indicated client #4 had a "Pressure Ulcer" to the "Right Ischium" (lower back part of the hip bone). The wound clinic note indicated client #4's wound was open,</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>had red brown drainage and was "Unstageable/Unclassified." The note indicated client #4's wound measured 0.5 centimeters by 9.5 centimeters and 0.4 centimeters in depth.</p> <p>Client #4's Nurse's Notes indicated the following (not all inclusive):</p> <p>-4/22/14 Client #4 was admitted to the group home on 4/22/14. The note indicated "...there is a 1 x 1.5 inch wound on back of (L) thigh, with 4 1/2 cm hole in middle of wound, no drainage, no pain complaints (sic)...."</p> <p>-5/7/14 Seen by a doctor for a wound evaluation. The note indicated a culture was obtained and an x-ray was done to "...rule out a foreign object being in the wound....."</p> <p>-5/13/14 Client #4 was seen by Physical Therapy (PT) and Occupational Therapy (OT) for an evaluation. The note indicated "...PT only recommends a better reclining W/C (wheelchair) and splints to help with ankle contractures...."</p> <p>-5/14/14 "[Client #4] saw [name of doctor] for wound care today. The would cultures did not grow any bacteria. [Name of doctor] is referring her to [name of doctor], plastic surgeon, for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>consult on having the area excised and repaired...."</p> <p>-6/2/14 "[Client #4] saw [name of doctor], plastic surgeon to evaluate the wound (L) posterior thigh. He wants to perform a biopsy on the tissue in the wound before considering surgery to remove the unhealthy tissue...."</p> <p>-7/14/14 "[Client #4] had the biopsy/excision of tissue from (L) posterior thigh wound at [name of hospital] surgery today...."</p> <p>-7/28/14 "[Name of doctor's] office reports pathology is back. No cancer found...."</p> <p>-8/7/14 "...He (primary care doctor) noticed slight swelling to BLE (bilateral extremities) and states 'it is from being in her w/c and elevation will help.'...."</p> <p>-8/19/14 "[Client #4] was taken for a wheelchair evaluation at [name of company] in [name of city]. She was evaluated for needs for a specialized wheelchair and the salesman doing the eval repaired all parts of her current wheel chair that he could. He will call in the next week with information in regards (sic) to a new chair...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>-9/8/14 "Staff contacted this nurse stating '[client #4's] wound has 2 spots that have opened.' Upon assessment this writer finds a 5.2 inch surgical scar intact except two small open areas. First open area measures 8mm long and 4mm across. The second open area measures 4mm long and and 2mm wide. Area is not res, warm, or inflammed (sic) in appearance. Very small amount of drainage. [Client #4] has no fever or other s/s (signs/symptoms) of infection at this time. Applied bacitracin (antibiotic cream) to areas, covered with 4 x 4 gauze to protect integrity of wound and will continue to monitor [client #4] for s/s of infection. [Name of doctor] who did surgery to this wound contacted and appt (appointment) made for this Friday as this was the soonest that the doctor had available."</p> <p>-9/12/14 Client #4 saw the surgeon for the 2 new open areas. The note indicated "...[Name of doctor] briefly looked over the open areas and states 'that will heal on its won, just keep an eye on it, cover with gauze if needed,' This nurse questioned [name of doctor] if he thought it is tunneled under the open areas. His response was to place the tip of a q tip in both open areas, moved it around and states 'no this is only superficial'...Doctor encourages continuing on the vitamins</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>she receives and good nutrition. 'that (sic) helps the most' per [name of doctor]...."</p> <p>-9/15/14 "Upon evaluating [client #'s] surgical wound it was found to have 3 new open areas. The first open area (documented on 9-8-14) is now 10mm long x 6mm wide, no change in depth. A new open area below that measures 3mm long x 1mm wide, another new open area below that measures 1 mm x 1 mm and a new area right next to that measures 2mm x 1mm. The last open area (also documented on 9-8-14) now measures 5 mm long x 2mm wide, no change in depth. The skin around and within open areas is (sic) pink and appears to be healthy tissue, there is slight (scant) amount of bloody drainage from the open areas. No foul smell...Staff will continue to monitor for s/s of infection and to apply bacitracin PRN (as needed). Should any s/s of infection occur this nurse will contact [name of doctor] by phone as he ordered."</p> <p>-9/22/14"Weekly wound assessment (L) posterior thigh. No new open areas since last assessment on 9-15-14, same 5 open areas all with change in size. 1st (First) area measures 8 x 4mm, below that 15 x 7 mm, below that 3 x 2 mm, further down the surgical scar is open area now measuring 5 x 4 mm, and last area now</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>measuring 17 x 8 mm...This nurse has had no reply to multiple phone calls and faxes to [name of doctor] so contacted [name of primary care doctor (PCP)], he gave referral to go back to [name of hospital] wound center. Appt at wound center scheduled for 9/30/14 at 1045 AM."</p> <p>-9/29/14 "Weekly wound assessment (L) posterior thigh. No new open areas the two open areas in middle of scar have now combined to one, making 4 open areas at this time (sic). Open areas measure at 20mm x 6 mm, 14mm x 9mm (this was the two separate areas now joined together. 18 mm x 9mm and 2,, x 2mm. No evidence of infection at this time. Within the open areas tissue is pink, moist, no purulent drainage, no foul odor...The skin around open areas is (sic) becoming a dark red color but no other signs of skin breakdown in surrounding area. Wound center was contacted to confirm tomorrow's appt and his nurse was advised that [name of surgeon's] office has still 0 (not) sent a release so they may see/tx (treat) her. Wound center rescheduled appt to 10/6/14 in hopes that [name of surgeon] will release her to wound center's care. [Name of surgeon's] office faxed information in regards to today's (sic) wound eval."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-10/2/14 "Staff reported that there is the start of purulent drainage from [client #4's] left posterior thigh wound. Upon assessment small amount of green-ish drainage coming from all four open areas of wound...[Name of doctor], PCP was contacted due to being released from [name of surgeon's] care and initial appt (with) wound care not being until Monday (10/6/14). [Name of PCP] Rx'd (ordered) Augmentin 10 ml (milliliters) BID (two times a day) x 7 days...."</p> <p>-10/6/14 "[Client #4] was seen by [name of doctor] at [name of hospital] wound care. Wound was assessed measuring 11.7 L (long) x 0.5 W (wide) x 0.4 cm D (deep) (this is two of the open areas from last week that have combined to one larger area), the next open area measures 0.5 L x 9.5 W, 0.4 cm D, the third open area measures 0.5 cm L x 1.0 W. Reddish brown serosanguineous drainage, very minimal. The area was debrided...[name of doctor] gave orders to rinse wound (with) saline, apply hydrogel to 4 x 4 gauze, cover wound and tape into place (with) mepilex tape and changed (sic) once daily. [Name of doctor] obtained a culture of the area and recommends a ROHO cushion for her W/C until her custom W/C arrives. [Name of doctor] feels this wound has opened due to pressure and he is in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>agreement (with) our repositioning plan already in place for [client #4]...."</p> <p>Client #4's 5/13/14 Outpatient Physical Therapy (PT) Evaluation Summary indicated "Pt (patient) doesn't need skilled PT @ (at) this time however, needs appropriate W/C (wheelchair) &amp; (and) splinting; recommends a tilt-in space W/C (with) anti-tippers in front; foot &amp; leg cushioned supports for W/C;...." Client #4's record indicated client #4's PCP wrote an order for a "Reclining Wheel Chair and Ankle Splints on 6/2/14.</p> <p>Client #4's 9/5/14 Seating/Mobility Evaluation indicated client #4 had a wheelchair evaluation completed on 9/5/14. The evaluation indicated "...Reason for Referral: Needs New Wheelchair and postural seating...." The evaluation indicated client #4 had problems with bilateral knee contractures and Kyphosis (curving of the spine). The evaluation indicated client #4's current wheelchair was "...Poor, not appropriate to her needs. Problems with Current Mobility base: Too large, lacks tilt-in-space..." which caused client #4's head and trunk to "fall forward." The assessment indicated client #4 had been "...W/C bound most of pt's (patient's) life...." The 9/5/14 assessment indicated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"Pt unable to transfer, stand, walk, or perform ADL's (Adult Daily Living Skills)." The assessment also indicated client #4 required a seat cushion as the client's present wheelchair did not have one. The 9/5/14 assessment indicated client #4 needed a seat cushion as the client had "Impaired sensation, decubitus ulcers present, history of decubitus ulcers, increase pressure distribution, stabilize pelvis, prevent pelvic extension, and to accommodate multiple deformity...." The 9/5/14 evaluation indicated client #4 required a tilt and reclining wheelchair which included a head rest, seat board, back cushion, foot box, seat cushion and a seat belt.</p> <p>A 9/25/14 Outpatient Physical Therapy Evaluation Summary sheet indicated "Significant contractures noted in (B) (both) LE's (lower extremities) in all joints. Pt is legally blind and has Moderate M.R. (Mental Retardation) so self-propulsion not an option. Open wound on post. (posterior) left thigh so custom seating needed...."</p> <p>Client #4's 5/21/14 Repositioning Plan indicated "...[Client #4] needs to be repositioned every two hours throughout the 24 hour day. [Client #4] will be rotated from bed, to wheelchair to recliner every two hours, and while in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>recliner she is to be on her left side (completely off her buttocks) for 1 hour then rolled to the right side (completely off of buttocks) and then she can go back to her wheelchair or bed. While in her hospital bed with special air mattress, she will be rolled from left to right side every 2 hours."</p> <p>Client #4's September 2014 (day program) Repositioning/Bathroom chart indicated facility staff did not reposition/document client #4 was repositioned every 2 hours from 9:00 AM to 3:00 PM while at the facility's owned day program.</p> <p>Client #4's October 2014 Consumer Nightly Check Record indicated facility staff were to document "P" for repositioning. The October 2014 chart indicated facility staff did not document client #4 was repositioned every 2 hours from 3:00 PM to 9:00 PM from October 1, 2014 to October 10, 2014.</p> <p>Client #4's September 2014 Consumer Nightly Check Record did not indicate client #4 was repositioned every 2 hours from 3:00 PM to 9:00 PM on 9/2, 9/3, 9/7, 9/15, 9/16, 9/19, 9/20, 9/22, 9/23, 9/29 and 9/30/14. Client #4's above mentioned repositioning schedules indicated facility staff did not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicate/document how client #4 was repositioned every 2 hours as only "P," "S," (sleeping) "U," (out of bed) and/or "B" (bathroom) was indicated/documentated.</p> <p>Interview with LPN #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 10/9/14 at 2:18 PM, by phone, indicated client #4 had a history of pressure ulcers. LPN #1 indicated client #4 was admitted to the group home in 4/2014 from another facility. LPN #2 indicated client #4 had an area on the back of her thigh at that time. LPN #1 indicated client #4 was seen by a plastic surgeon and had surgery to the area. LPN #1 indicated client #4 was taken back to the see the plastic surgeon as the client had 2 open areas on the back of her thigh. LPN #1 indicated the surgeon stated the areas were "superficial." LPN #1 indicated the doctor indicated the areas would heal on their own. LPN #1 indicated she was completing weekly assessments of client #4's wounds. LPN #1 indicated client #4 now had 4 different open areas on the back of the client's thigh as the client had developed new areas. LPN #1 indicated she had a hard time getting the surgeon to return her phone calls and to get the surgeon to refer the client to a wound clinic. LPN #1 stated "She got worse because [name of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>doctor] would not release her to wound care." LPN #1 stated the wound care doctor indicated the areas were from "pressure due to the client's wheelchair." LPN #1 stated client #4's wheelchair is "not appropriate for her." LPN #1 and the QIDP stated client #4 needed a "specialized wheelchair." LPN #1 and the QIDP indicated client #4 had a wheelchair evaluation but "Medicaid is going to cover small portion so we are trying to do a second evaluation recommended by [name of company] who will make the wheelchair." LPN #1 stated "It is being fought out between the Insurance (Medicaid) and Bona Vista" in regard to who will pay for client #4's wheelchair. The QIDP and LPN #1 indicated facility staff were repositioning the client every 2 hours. LPN #1 indicated the wound clinic doctor indicated the doctor reviewed their repositioning plan and indicated it should continue. LPN #1 indicated facility staff should move client #4 from her wheelchair to the recliner when repositioning. LPN #1 indicated client #4 would be getting a ROHO cushion for her wheelchair as ordered by the wound doctor. LPN #1 indicated Medicaid also would not pay for the ROHO cushion.</p> <p>The facility's policy and procedures were reviewed on 10/8/14 at 12:00 PM. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000159	<p>facility's undated policy entitled Prohibition of Violations of Individual Rights 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 individual or violation of an individual's rights by employees or agents delivering services on behalf of the agency." The facility's undated policy defined neglect as "Failure to provide supervision, training, appropriate care, food, medical care or medical supervision to an individual...."</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on interview and record review for 3 of 4 sampled clients (#2, #3 and #4), the Qualified Intellectual Disabilities Professional (QIDP) failed to monitor the clients' Individual Support Plans (ISPs)/objectives/data to ensure the clients' objectives were revised as needed.</p> <p>Findings include:</p>	W000159	<p><b>To ensure adequate monitoring of client progress and goals reached through the ISPs and other objectives and data, the following corrective action(s) will be implemented:</b> 1) The Qualified Intellectual Disabilities Professional (QIDP) will review client program goals and objectives on a weekly basis to ensure proper programming has occurred and is documented. The QIDP will then submit a monthly report to the Director and Vice</p>	11/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>1. Client #2's record was reviewed on 10/9/14 at 8:30 AM. Client #2's 12/11/13 ISP indicated client #2 had the following ISP objectives:</p> <ul style="list-style-type: none"> <li>-To point to a picture cue when given Allegra (allergies) with 2 or less verbal prompts 50% of the time for 30 trials.</li> <li>-To hold her wash cloth under the shower to get wet 5 of 5 trials with 1 verbal prompt.</li> <li>-To hold her toothbrush to her mouth with 2 verbal prompts 50% of the time for 30 sessions.</li> <li>-To take smaller bites of food during meals with 2 or less verbal prompts for 30 trials.</li> <li>-To choose a shirt to wear with 2 verbal prompts 50% of the time for 30 sessions/trials.</li> <li>-To identify the correct coin by pointing at it with 2 or less verbal prompts 50% of the time for 8 trials.</li> <li>-To put food and drink into my lunch bag with 1 verbal prompt 50% of the time for 20 trials.</li> <li>-To throw away her soiled brief with 2 or less verbal prompts 50% of the time for 30 sessions/trials.</li> </ul> <p>Client #2's record indicated client #2 had Monthly Reports (monthly summaries) for February 2014, May 2014 and August 2014 which reviewed the data/progress of</p>		President of Residential Services for review that includes detailed data regarding percentages of goals being attempted and reached. Refer to Appendix E for Monthly Template form to be used.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>client #2's 12/11/13 ISP objectives. Client #2's record did not indicate the facility's QIDP completed any additional monthly summaries/quarterly reviews of client #2's above mentioned ISP objectives to determine if the client's objectives needed to be revised.</p> <p>2. Client #3's record was reviewed on 10/8/14 at 1:44 PM. Client #3's 2/11/14 ISP indicated client #3 had the following ISP objectives:</p> <ul style="list-style-type: none"> <li>-To relax her fingers so staff could wash her palms with warm water and massaging the top of her hand 50% of the time.</li> <li>-To open her mouth and stick out her tongue for staff to brush her tongue with 1 verbal prompt 75% of the time for 30 sessions.</li> <li>-When given 2 choices, she will chose her food by looking at it before it is pureed with 1 verbal prompt for 30 sessions.</li> <li>-To choose a penny when shown 2 different coins, by looking at the penny for 5 seconds, with 2 or less verbal prompts 50% of the time for 30 sessions.</li> <li>-To move her eyes and head when a picture was held up to her to view from different sides of the chair and at different angles 100% of the time for 12 sessions.</li> </ul>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>-To stretch her elbows when in the shower with physical assistance 100% of the time for 30 sessions.</p> <p>-To respond to staff request to relax at her medication pass 100% of the time for 30 sessions.</p> <p>Client #3's record indicated client #3 had a Quarterly Review dated February 2014 and a May 2014 Monthly Report which reviewed the data/progress of client #3's 2/11/14 ISP objectives. Client #3's record did not indicate the facility's QIDP completed any additional monthly summaries/quarterly reviews of client #3's above mentioned ISP objectives to determine if the client's objectives needed to be revised.</p> <p>3. Client #4's record was reviewed on 10/8/14 at 3:40 PM. Client #4's 5/21/14 ISP indicated client #4 had the following objectives:</p> <p>-To take a fork from staff with 2 or less verbal prompts 50% of the time for 30 sessions.</p> <p>-To raise her head to rinse shampoo out with 2 or less verbal prompts and hand over hand assistance (HOH).</p> <p>-To run a brush through her hair 3 times with 2 or less verbal prompts 50% of the time for 30 sessions.</p> <p>-To swab her gums with 2 or less verbal</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>prompts 50% of the time for 30 sessions. -To identify a coin using HOH technique with 4 or less verbal prompts 50% of the time for 8 sessions. -To participate in activities with her peers with no more than 2 verbal prompts 50% of the time for 30 sessions. -To identify why she takes Depakote (behavior) with no more than 2 verbal prompts 50% of the time for 30 sessions. -To identify ways to relax when she becomes upset with no more than 2 verbal prompts 50% of the time for 8 sessions.</p> <p>Client #4's record indicated client #4 had Monthly Reports for May 2014 and August 2014 which reviewed the data/progress of client #4's 5/21/14 ISP objectives. Client #4's record did not indicate the facility's QIDP completed any additional monthly summaries/quarterly reviews of the client's above mentioned ISP objectives to determine if the client's objectives needed to be revised.</p> <p>Interview with the QIDP, by phone, on 10/9/14 at 2:18 PM indicated she was completing quarterly reviews of client #1, #2, #3 and #4's ISP objectives. The QIDP did not provide any additional documentation/reviews of the clients' ISP objectives to indicate the clients'</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000252	<p>objectives were being reviewed/revised when needed.</p> <p>9-3-3(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on interview and record review for 1 of 4 sampled clients (#4), the facility failed to document the client was being repositioned every 2 hours as indicated in the client's Repositioning Risk Plan.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/8/14 at 11:36 AM. The facility's reportable incident report indicated the following:</p> <p>-9/8/14 "It was reported on 9/8/14 there was 2 very small open areas on [client #4's] thigh. The nurse came in to assess the area. [Client #4] has no fever, the area is not red, warm, or inflamed (sic) and [client #4] has not complained of pain. There is a small amount of drainage but no signs of infection or bleeding from that area. Nurse also noted</p>	W000252	<p><b>Toensure proper repositioning as indicated in the Repositioning Risk Plan, thefollowing corrective action(s) will be implemented:</b></p> <p>1) All staff located at 1413 DarbyStreet (Darby group home) will be re-trained on the Repositioning Risk Plan forClient #4 to ensure proper knowledge of repositioning needs. The ResidentialHouse Manager and Residential Nurse will routinely review the repositioningtracking sheet to ensure that proper repositioning is occurring as directed inthe risk plan. Should a staff member fail to reposition Client #4 as indicatedin the risk plan, he or she will be counseled per</p>	11/16/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the 5.2 inch surgical scar from [client #4's] surgery (biopsy on 7/15/14) intact with the exception of two small open areas. First area measures 8mm (millimeter) long and 4mm across. The second measures 4mm long and 2mm wide. In an effort to prevent infection and prevent the open area from drying out and skin breakdown, bacitracin (antibiotic ointment) is being applied to the area and covered with a 4 x (by) 4 gauze. Also, a folded towel between the area on left posterior thigh and the seat of her wheelchair, to cushion the area and prevent any type of shearing to the area and staff will keep the area clean and dry and to continue to monitor [client #4] for signs and symptoms of infection until [client #4] visits the plastic surgeon. [Client #4's] appointment with the plastic surgeon is scheduled for 9/12/14."</p> <p>-A 9/15/14 follow-up report indicated "1. On 9/12/14 [client #4] was seen by the plastic surgeon due to 2 new open areas on surgical wound area on left thigh. The doctor briefly looked over the open areas and stated that will heal on it's own. There has been no change in size and appearance, or new drainage since the last report. The doctor recommended to cover with gauze and to monitor it. Question asked if this may have tunneled from another area and he then put a Qtip</p>		agency personnel policies and procedures. Refer to Appendix D for Record of Training form to be used.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>in the open area and he determined it to be superficial. If signs of infection then to contact him for an antibiotic if needed. Doctor also encourage vitamins and good nutrition that would help the most."</p> <p>-A 9/22/14 follow-up to the 9/8/14 reportable incident report indicated client #4 had been placed on a multivitamin and vitamin C "to help with wound healing." The 9/22/14 follow-up report indicated "...Her wound care has been monitored by staff and weekly assessment by nurse to find 3 more open areas since her visit on 9/12/14. The wounds since last report have reopened wider one from 8mm long and 4mm wide is now 10mm longx6mm (sic) wide. The 3 new open areas are 3mm long x 1mm wide, 1mm x 1mm wide, and 2mm x 1mm. No signs or symptoms of infection and the depth is unchanged. Physician contacted and recommended wound center and this appointment made for Sept. (September) 30."</p> <p>-A 9/30/14 follow-up to the 9/8/14 reportable incident report indicated "1. As a nursing measure [client #4] has a bandage applied to her and changed daily to keep any infection out until her visit with the wound center. 2. There have been several attempts to contact the cosmetic surgeon to release care back to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the wound center before [client #4] will be seen. She was not released in time for 9/30/14 appointment. The appointment is rescheduled for 10/6/14."</p> <p>-A 10/6/14 follow-up report to the 9/8/14 reportable incident report indicated "1. From last report filed [client #'s] open areas have changed. She had 5 total areas that became 3 due to areas opened wider creating 3 open areas. Depth of an open area did not change however on she had green drainage since last report (sic). Nurse called [client #'s] general physician to order an antibiotic. [Client #4] went to the wound center today and the doctor found no evidence of infection and much improved at this time. To continue the antibiotic prescribed by the general physician. The doctor from the wound center ordered hydrogel (wound care product) and 4x4 gauze with meplix (sic) (wound care dressing) dressing to be changed one time daily. He also ordered Roho cushion for wheelchair until chair is replaced by specialized chair. He also ordered for [client #4] to be repositioned every 2 hours (already in place). She has another visit to the wound center next Monday on 10/13/14."</p> <p>During the 10/7/14 observation period between 3:25 PM and 6:00 PM and the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>10/8/14 observation period at the group home, client #4 utilized a wheelchair for her primary means of mobility. Client #4 required facility staff to push/maneuver the wheelchair. Client #4's legs/feet dangled down from the wheelchair near and/or in between the 2 footrests on the client's wheelchair. Client #4's feet were deformed and could not rest on the footrests of the wheelchair. Client #4's wheelchair was a regular wheelchair with foot rests.</p> <p>Client #4's record was reviewed on 10/8/14 at 340 PM. Client #4's 5/21/14 Repositioning Plan indicated "...[Client #4] needs to be repositioned every two hours throughout the 24 hour day. [Client #4] will be rotated from bed, to wheelchair to recliner every two hours, and while in the recliner she is to be on her left side (completely off her buttocks) for 1 hour then rolled to the right side (completely off of buttocks) and then she can go back to her wheelchair or bed. While in her hospital bed with special air mattress, she will be rolled from left to right side every 2 hours."</p> <p>Client #4's September 2014 (day program) Repositioning/Bathroom chart indicated facility staff did not reposition/document client #4 was repositioned every 2 hours from 9:00 AM</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>to 3:00 PM while at the facility's owned day program.</p> <p>Client #4's October 2014 Consumer Nightly Check Record indicated facility staff were to document "P" for repositioning. The October 2014 chart indicated facility staff did not document client #4 was repositioned every 2 hours from 3:00 PM to 9:00 PM from October 1, 2014 to October 10, 2014.</p> <p>Client #4's September 2014 Consumer Nightly Check Record did not indicate client #4 was repositioned every 2 hours from 3:00 PM to 9:00 PM on 9/2, 9/3, 9/7, 9/15, 9/16, 9/19, 9/20, 9/22, 9/23, 9/29 and 9/30/14. Client #4's above mentioned repositioning schedules indicated facility staff did not indicate/document how client #4 was repositioned every 2 hours as only "P," "S," (sleeping) "U," (out of bed) and/or "B" (bathroom) was indicated/documentated.</p> <p>Interview with LPN #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 10/9/14 at 2:18 PM, by phone, indicated client #4 had a history of pressure ulcers. LPN #1 indicated client #4 was admitted to the group home in 4/2014 from another facility. The QIDP and LPN #1 indicated facility staff were</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000263	<p>repositioning the client every 2 hours. LPN #1 indicated the wound clinic doctor indicated the doctor reviewed their repositioning plan and indicated it should continue. LPN #1 indicated facility staff should move client #4 from her wheelchair to the recliner when repositioning.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 2 of 2 clients (#1 and #4) with restrictive programs, the facility failed to obtain written informed consent for the clients' restrictive programs.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/8/14 at 2:48 PM. Client #1's 8/11/14 physician's orders indicated the client received Abilify, Paxil and Xanax for behaviors.</p> <p>Client #1's August 2014 Behavior Support Plan (BSP) indicated client #1</p>	W000263	<p><b>Toensure approval for all restrictive measures and programs, the followingcorrective action(s) will be implemented:</b></p> <p>1) TheQualified Intellectual Disabilities Professional (QIDP) will seek emergencyapproval for restrictive programming being utilized in the home. Writtenapproval will then be placed in the files of consumers accordingly.</p> <p>2) Uponapproval, the QIDP will review all Behavior</p>	11/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>demonstrated physical aggression toward others. Client #1's BSP indicated facility staff were allowed to use physical intervention when the client became aggressive toward others.</p> <p>Client #1's 8/12/14 Individual Support Plan (ISP) indicated client #1's parents were the client's guardians. Client #1's 8/12/14 ISP and/or August 2014 BSP did not indicate client #1's guardians gave written informed consent for the above mentioned restrictions.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 10/9/14 at 2:18 PM, by phone, indicated client #1's guardian did not give written informed consent for the client's restrictive program. The QIDP stated "We did over the phone." The QIDP indicated the client's guardian gave verbal consent only.</p> <p>2. Client #4' record was reviewed on 10/8/14 at 3:40 PM. Client #4's 8/6/14 physician's orders indicated client #4 received Abilify, Valproic Acid for behaviors and Escitalopram for anxiety.</p> <p>Client #4's June 2014 BSP indicated when client #4 became aggressive toward others and/or was not "safe," the facility staff could utilize CPI (Crisis Prevention</p>		<p>Support Plans (BSP) to ensure that each plan contains verification of approved restricted measures and how the restrictive measures are to be applied. All staff located at 1413 Darby Street (Dabry group home) will be retrained on their revised individual BSPs. Completed Record of Trainings will be obtained and submitted upon completion of training.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000312	<p>Intervention) techniques to help assist the client to calm down.</p> <p>Client #4's 5/21/14 ISP indicated client #4's sister was the client's guardian. The 5/21/14 ISP and/or June 2014 BSP did not indicate the client's sister gave written informed consent in regard to the use of the behavioral medications, and/or restrictive techniques included in the client's BSP.</p> <p>Interview with the QIDP on 10/9/14 at 2:18 PM, by phone, indicated client #4's guardian did not give written informed consent for the client's restrictive program. The QIDP indicated client #4's guardian gave consent over the phone.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 2 of 2 sampled clients (#1 and #4), on behavioral medications, the facility failed to ensure each medication used for behaviors were a part of the clients'</p>	W000312	<b>Toensure proper documentation and use of behavioral medications, the followingcorrective action(s) will be implemented:</b>	11/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>behavioral programs.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/8/14 at 2:48 PM. Client #1's 8/11/14 physician's orders indicated the client received Abilify, Paxil and Xanax for behaviors.</p> <p>Client #1's August 2014 Behavior Support Plan (BSP) indicated client #1's Paxil was not part of the client's behavior plan as the client's behavior plan indicated client #1 received Abilify and Xanax for behaviors.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 10/9/14 at 2:18 PM, by phone, indicated client #1 received Paxil for behavior. The QIDP indicated client #1's Paxil should have been included as a behavioral medication in the client's BSP.</p> <p>2. Client #4' record was reviewed on 10/8/14 at 3:40 PM. Client #4's 8/6/14 physician's orders indicated client #4 received Abilify, Valproic Acid for behaviors and Escitalopram for anxiety.</p> <p>Client #4's June 2014 BSP indicated client #4's Abilify was not part of the client's BSP as the BSP indicated client</p>		<p>1) The Qualified Intellectual Disabilities Professional (QIDP) will revise all Behavior Support Plans (BSP) to include proper documentation and use of behavioral medications as indicated in physicians' orders. All staff located at 1413 Darby Street (Dabry group home) will be retrained on the revised individual BSPs. Completed Record of Trainings will be obtained and submitted upon completion of training.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000436	<p>#4 received the behavioral medications of Valproic Acid and Escitalopram.</p> <p>Interview with the QIDP on 10/9/14 at 2:18 PM, by phone, indicated client #4's received Abilify for behaviors. The QIDP indicated client #4's Abilify should have been included as a behavioral medication in the client's BSP.</p> <p>9-3-4(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, interview and record review for 1 of 4 sampled clients with adaptive equipment, the facility failed to ensure a client had the required adaptive equipment to prevent/reduce the client's pressure ulcers.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/8/14 at 11:36 AM. The facility's reportable incident report indicated the following:</p>	W000436	<p><b>Toensure that Client #4 has received the appropriate and recommended adaptiveequipment, the following corrective action(s) will be implemented:</b></p> <p>1) OnOctober 15, 2014, the reclining wheelchair as recommended by the prescribingphysician was ordered for Client #4. Asper current communications with NuMotion, two more parts are needed to completeassembly</p>	11/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>-9/8/14 "It was reported on 9/8/14 there was 2 very small open areas on [client #4's] thigh. The nurse came in to assess the area. [Client #4] has no fever, the area is not red, warm, or inflamed (sic) and [client #4] has not complained of pain. There is a small amount of drainage but no signs of infection or bleeding from that area. Nurse also noted the 5.2 inch surgical scar from [client #4's] surgery (biopsy on 7/15/14) intact with the exception of two small open areas. First area measures 8mm (millimeter) long and 4mm across. The second measures 4mm long and 2mm wide. In an effort to prevent infection and prevent the open area from drying out and skin breakdown, bacitracin (antibiotic ointment) is being applied to the area and covered with a 4 x (by) 4 gauze. Also, a folded towel between the area on left posterior thigh and the seat of her wheelchair, to cushion the area and prevent any type of shearing to the area and staff will keep the area clean and dry and to continue to monitor [client #4] for signs and symptoms of infection until [client #4] visits the plastic surgeon. [Client #4's] appointment with the plastic surgeon is scheduled for 9/12/14."</p> <p>-A 9/15/14 follow-up report indicated "1. On 9/12/14 [client #4] was seen by the</p>		of the wheelchair. Upon assembly and completion, the wheelchair will be delivered and provided for Client #4.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>plastic surgeon due to 2 new open areas on surgical wound area on left thigh. The doctor briefly looked over the open areas and stated that will heal on it's own. There has been no change in size and appearance, or new drainage since the last report. The doctor recommended to cover with gauze and to monitor it. Question asked if this may have tunneled from another area and he then put a Qtip in the open area and he determined it to be superficial. If signs of infection then to contact him for an antibiotic if needed. Doctor also encourage vitamins and good nutrition that would help the most."</p> <p>-A 9/22/14 follow-up to the 9/8/14 reportable incident report indicated client #4 had been placed on a multivitamin and vitamin C "to help with wound healing." The 9/22/14 follow-up report indicated "...Her wound care has been monitored by staff and weekly assessment by nurse to find 3 more open areas since her visit on 9/12/14. The wounds since last report have reopened wider one from 8mm long and 4mm wide is now 10mm longx6mm (sic) wide. The 3 new open areas are 3mm long x 1mm wide, 1mm x 1mm wide, and 2mm x 1mm. No signs or symptoms of infection and the depth is unchanged. Physician contacted and recommended wound center and this appointment made for Sept. (September)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>30."</p> <p>-A 9/30/14 follow-up to the 9/8/14 reportable incident report indicated "1. As a nursing measure [client #4] has a bandage applied to her and changed daily to keep any infection out until her visit with the wound center. 2. There have been several attempts to contact the cosmetic surgeon to release care back to the wound center before [client #4] will be seen. She was not released in time for 9/30/14 appointment. The appointment is rescheduled for 10/6/14."</p> <p>-A 10/6/14 follow-up report to the 9/8/14 reportable incident report indicated "1. From last report filed [client #'s] open areas have changed. She had 5 total areas that became 3 due to areas opened wider creating 3 open areas. Depth of an open area did not change however on she had green drainage since last report (sic). Nurse called [client #'s] general physician to order an antibiotic. [Client #4] went to the wound center today and the doctor found no evidence of infection and much improved at this time. To continue the antibiotic prescribed by the general physician. The doctor from the wound center ordered hydrogel (wound care product) and 4x4 gauze with meplix (sic) (wound care dressing) dressing to be changed one time daily.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>He also ordered Roho cushion for wheelchair until chair is replaced by specialized chair. He also ordered for [client #4] to be repositioned every 2 hours (already in place). She has another visit to the wound center next Monday on 10/13/14."</p> <p>During the 10/7/14 observation period between 3:25 PM and 6:00 PM and the 10/8/14 observation period at the group home, client #4 utilized a wheelchair for her primary means of mobility. Client #4 required facility staff to push/maneuver the wheelchair. Client #4's legs/feet dangled down from the wheelchair near and/or in between the 2 footrests on the client's wheelchair. Client #4's feet were deformed and could not rest on the footrests of the wheelchair. Client #4's wheelchair was a regular wheelchair with foot rests.</p> <p>Client #4's record was reviewed on 10/8/14 at 340 PM. Client #4's Nurse's Notes indicated the following (not all inclusive):</p> <p>-4/22/14 Client #4 was admitted to the group home on 4/22/14. The note indicated "...there is a 1 x 1.5 inch wound on back of (L) thigh, with 4 1/2 cm hole in middle of wound, no drainage, no pain complaints (sic)...."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-5/7/14 Seen by a doctor for a wound evaluation. The note indicated a culture was obtained and an x-ray was done to "...rule out a foreign object being in the wound....."</p> <p>-5/13/14 Client #4 was seen by Physical Therapy (PT) and Occupational Therapy (OT) for an evaluation. The note indicated "...PT only recommends a better reclining W/C (wheelchair) and splints to help with ankle contractures...."</p> <p>-8/7/14 "...He (primary care doctor) noticed slight swelling to BLE (bilateral extremities) and states 'it is from being in her w/c and elevation will help.'...."</p> <p>-8/19/14 "[Client #4] was taken for a wheelchair evaluation at [name of company] in [name of city]. She was evaluated for needs for a specialized wheelchair and the salesman doing the eval repaired all parts of her current wheel chair that he could. He will call in the next week with information in regards (sic) to a new chair...."</p> <p>-9/8/14 "Staff contacted this nurse stating '[client #4's] wound has 2 spots that have opened.' Upon assessment this writer finds a 5.2 inch surgical scar intact except two small open areas. First open</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>area measures 8mm long and 4mm across. The second open area measures 4mm long and 2mm wide. Area is not res, warm, or inflamed (sic) in appearance. Very small amount of drainage. [Client #4] has no fever or other s/s (signs/symptoms) of infection at this time...."</p> <p>-9/12/14 Client #4 saw the surgeon for the 2 new open areas. The note indicated "...[Name of doctor] briefly looked over the open areas and states 'that will heal on its won, just keep an eye on it, cover with gauze if needed,' This nurse questioned [name of doctor] if he thought it is tunneled under the open areas. His response was to place the tip of a q tip in both open areas, moved it around and states 'no this is only superficial'...Doctor encourages continuing on the vitamins she receives and good nutrition. 'that (sic) helps the most' per [name of doctor]...."</p> <p>-9/15/14 "Upon evaluating [client #4's] surgical wound it was found to have 3 new open areas. The first open area (documented on 9-8-14) is now 10mm long x 6mm wide, no change in depth. A new open area below that measures 3mm long x 1mm wide, another new open area below that measures 1 mm x 1 mm and a new area right next to that measures 2mm x 1mm. The last open area (also</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>documented on 9-8-14) now measures 5 mm long x 2mm wide, no change in depth. The skin around and within open areas is (sic) pink and appears to be healthy tissue, there is slight (scant) amount of bloody drainage from the open areas. No foul smell...."</p> <p>-9/22/14"Weekly wound assessment (L) posterior thigh. No new open areas since last assessment on 9-15-14, same 5 open areas all with change in size. 1st (First) area measures 8 x 4mm, below that 15 x 7 mm, below that 3 x 2 mm, further down the surgical scar is open area now measuring 5 x 4 mm, and last area now measuring 17 x 8 mm...This nurse has had no reply to multiple phone calls and faxes to [name of doctor] so contacted [name of primary care doctor (PCP)], he gave referral to go back to [name of hospital] wound center...."</p> <p>-9/29/14 "Weekly wound assessment (L) posterior thigh. No new open areas the two open areas in middle of scar have now combined to one, making 4 open areas at this time (sic). Open areas measure at 20mm x 6 mm, 14mm x 9mm (this was the two separate areas now joined together. 18 mm x 9mm and 2,, x 2mm. No evidence of infection at this time. Within the open areas tissue is pink, moist, no purulent drainage, no foul</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>odor...The skin around open areas is (sic) becoming a dark red color but no other signs of skin breakdown in surrounding area. Wound center was contacted to confirm tomorrow's appt and his nurse was advised that [name of surgeon's] office has still 0 (not) sent a release so they may see/tx (treat) her. Wound center rescheduled appt to 10/6/14 in hopes that [name of surgeon] will release her to wound center's care. [Name of surgeon's] office faxed information in regards to today's (sic) wound eval."</p> <p>-10/6/14 "[Client #4] was seen by [name of doctor] at [name of hospital] wound care. Wound was assessed measuring 11.7 L (long) x 0.5 W (wide) x 0.4 cm D (deep) (this is two of the open areas from last week that have combined to one larger area), the next open area measures 0.5 L x 9.5 W, 0.4 cm D, the third open area measures 0.5 cm L x 1.0 W. Reddish brown serosanguineous drainage, very minimal. The area was debrided...[name of doctor gave orders to rinse wound (with) saline, apply hydrogel to 4 x 4 gauze, cover wound and tape into place (with) mepilex tape and changed (sic) once daily. [Name of doctor] obtained a culture of the area and recommends a ROHO cushion for her W/C until her custom W/C arrives. [Name of doctor] feels this wound has</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>opened due to pressure and he is in agreement (with) our repositioning plan already in place for [client #4]...."</p> <p>Client #4's 5/13/14 Outpatient Physical Therapy (PT) Evaluation Summary indicated "Pt (patient) doesn't need skilled PT @ (at) this time however, needs appropriate W/C (wheelchair) &amp; (and) splinting; recommends a tilt-in space W/C (with) anti-tippers in front; foot &amp; leg cushioned supports for W/C;...." Client #4's record indicated client #4's PCP wrote an order for a "Reclining Wheel Chair and Ankle Splints on 6/2/14.</p> <p>Client #4's 9/5/14 Seating/Mobility Evaluation indicated client #4 had a wheelchair evaluation completed on 9/5/14. The evaluation indicated "...Reason for Referral: Needs New Wheelchair and postural seating...." The evaluation indicated client #4 had problems with bilateral knee contractures and Kyphosis (curving of the spine). The evaluation indicated client #4's current wheelchair was "...Poor, not appropriate to her needs. Problems with Current Mobility base: Too large, lacks tilt-in-space..." which caused client #4's head and trunk to "fall forward." The assessment indicated client #4 had been "...W/C bound most of pt's (patient's)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>life...." The 9/5/14 assessment indicated "Pt unable to transfer, stand, walk, or perform ADL's (Adult Daily Living Skills)." The assessment also indicated client #4 required a seat cushion as the client's present wheelchair did not have one. The 9/5/14 assessment indicated client #4 needed a seat cushion as the client had "Impaired sensation, decubitus ulcers present, history of decubitus ulcers, increase pressure distribution, stabilize pelvis, prevent pelvic extension, and to accommodate multiple deformity...." The 9/5/14 evaluation indicated client #4 required a tilt and reclining wheelchair which included a head rest, seat board, back cushion, foot box, seat cushion and a seat belt.</p> <p>A 9/25/14 Outpatient Physical Therapy Evaluation Summary sheet indicated "Significant contractures noted in (B) (both) LE's (lower extremities) in all joints. Pt is legally blind and has Moderate M.R. (Mental Retardation) so self-propulsion not an option. Open wound on post. (posterior) left thigh so custom seating needed...."</p> <p>Interview with LPN #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 10/9/14 at 2:18 PM, by phone, indicated client #4 had a history of pressure ulcers. LPN #1 indicated client</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#4 was admitted to the group home in 4/2014 from another facility. LPN #2 indicated client #4 had an area on the back of her thigh at that time. LPN #1 indicated client #4 was seen by a plastic surgeon and had surgery to the area. LPN #1 indicated client #4 was taken back to the see the plastic surgeon as the client had 2 open area on the back of her thigh. LPN #1 indicated the surgeon stated the areas were "superficial." LPN #1 indicated the doctor indicated the areas would heal on their own. LPN #1 indicated she was completing weekly assessments of client #4's wounds. LPN #1 indicated client #4 now had 4 different open areas on the back of the client's thigh as the client had developed new areas. LPN #1 stated "She got worse because [name of doctor] would not release her to wound care." LPN #1 stated the wound care doctor indicated the areas were from "pressure due to the client's wheelchair." LPN #1 stated client #4's wheelchair is "not appropriate for her." LPN #1 and the QIDP stated client #4 needed a "specialized wheelchair." LPN #1 and the QIDP indicated client #4 had a wheelchair evaluation but "Medicaid is going to cover small portion so we are trying to do a second evaluation recommended by [name of company] who will make the wheelchair." LPN #1 stated "It is being			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W009999	<p>fought out between the Insurance (Medicaid) and Bona Vista" in regard to who will pay for client #4's wheelchair. LPN #1 indicated client #4 would be getting a ROHO cushion for her wheelchair as ordered by the wound doctor. LPN #1 indicated Medicaid also would not pay for the ROHO cushion.</p> <p>9-3-7(a)</p> <p>STATE FINDINGS:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>(1) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and</p>	W009999	<p><b>Toensure that all personnel files contain the required documentation and that allemployed staff are in compliance with all applicable state and federal laws,the following corrective action(s) will be implemented:</b></p> <p>1) TheDirector of Residential Services will collaborate with the Vice President ofNursing Services to verify that all employees within the Residential ServicesDepartment are in compliance with all required testing training as per stateand federal laws. In the event that a staff member is out of</p>	11/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>THE STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for 1 of 4 personnel records reviewed (staff #2), the facility failed to obtain yearly PPD and/or a chest x-ray for an employed staff.</p> <p>Findings include:</p> <p>Staff #2's personnel record was reviewed on 10/8/14 at 12:56 PM. Staff #2's personnel record indicated staff #2 last had a Mantoux/Tuberculosis skin test on 8/12/13. Staff #2's personnel record indicated the staff person did not have a current chest x-ray and/or Mantoux test to ensure the staff person was free of TB.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP), by phone, on 10/9/14 at 2:18 PM indicated staff #2 did not have a current TB test. The QIDP stated "She is getting with agency nurse tomorrow. Got dropped."</p> <p>9-3-3(e)</p>		<p>compliance, the Director of Residential Services will direct the Residential House Manager to notify staff of the need to complete required tests or trainings.</p> <p>2) The Residential Services Coordinator will maintain a detailed database of required testing and trainings to ensure compliance within the department.</p> <p>3) Completed Record of Training forms or confirmation or verification of required testing will be placed in the personnel file of the employee within the Human Resources Department. The Residential Services Department will also maintain copies of these trainings and tests to ensure compliance.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	