

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2016
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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W 0000 Bldg. 00	<p>This visit was for a full recertification and state licensure survey.</p> <p>Dates of Survey: 2/23, 2/24, 2/25, 2/26 and 3/7/16.</p> <p>Facility number: 012485 Provider number: 15G789 AIM number: 201012970</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/14/16.</p>	W 0000		
W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview for 3 of 4 sampled clients (#1, #3 and #4), the facility failed to ensure the clients' rights were not violated by the use of door alarms with no titration plan</p>	W 0125	<p>W125 Finding(s): 1. "Based on observation, record review, and interview, for 3 of 4 sampled clients (#1, #3, and #4), the facility</p>	04/06/2016

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

TITLE

(X6) DATE

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

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	<p>in place.</p> <p>Findings include:</p> <p>During the 2/23/16 observation period between 4:00pm and 6:00pm in the group home clients went in and out the back door to smoke. Each time the back door was opened a door alarm would sound within the house.</p> <p>Client #1's record was reviewed on 2/25/16 at 3:32pm. Client #1's 11/4/15 elopement plan indicated "[client #1] has a history of elopement. DSP (Direct Support Professionals) will ensure the door alarms in the group home are on and functioning properly at all times." Client #1's elopement plan did not indicate how client #1 would get the door alarms shut off in his home.</p> <p>Client #3's record was reviewed on 2/26/16 at 11:12am. Client #3's February 2016 BSP (Behavior Support plan) indicated client #3 "has eloped from the group home and workshop when he becomes upset. There are HRC (Human Rights Committee) approved door and window alarms in the group home." Client #3's BSP did not indicate how client #3 would get the door alarms shut off in his home.</p>		<p>failed to ensure the clients had a plan in place which indicated what the clients had to do to get their right of freedom of movement back".</p> <p>Corrective Action(s):</p> <p>To ensure that established plans are written and in place for the clients to get their right of freedom of movement back, the following correction actions will be implemented:</p> <p>1. The Qualified Intellectual Disabilities Professional (QIDP) will write and implement titration plans for clients #1, #3, and #4 to get their right of freedom of movement back. The QIDP will obtain approval for these plans from the Human Rights Committee (HRC) prior to implementation. All staff located in the home will be trained on clients #1, #3, and #4's titration plans. All record of trainings will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p>				

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W 0154 Bldg. 00	<p>Client #4's record was reviewed on 2/26/16 at 3:03pm. Client #4's Feb 2016 BSP (Behavior Support Plan) indicated client #4 had a targeted behavior of elopement.</p> <p>Client #4's 4/8/15 elopement plan indicated "[client #4's] home is equipped with HRC approved window and door alarms to alert staff when consumers elope. The alarms are on when [client #4] is in the home."</p> <p>Client #4's BSP and/or elopement plan did not indicate how client #4 would get the door alarms shut off in her home.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if clients #1, #3 and #4 had titration plans for the door alarms, the RD stated "No they don't."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all</p>			

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	<p>alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 9 of 53 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to incidents of client to client aggression/abuse, staff to client neglect, and/or injuries of unknown origin for clients #2, #3 and #4.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 2/23/16 at 1:35pm. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations indicated the following (not all inclusive):</p> <p>-Client #4's 3/26/15 Accident report indicated client #4 had a 1 inch by 1 inch bruise between her breast and underarm. Client #4's 4/9/15 investigation in regards to the bruise indicated "[Staff #1] stated that [client #4] came home from workshop and informed her that she had a bruise. [Staff #1] asked [client #4] to go to her room so she could assess the bruise. [Staff #1] asked [client #4] if she knew where the bruise came from and</p>	W 0154	<p>W154</p> <p>Finding(s):</p> <p>1. "Based on interview and record review for 9 of 53 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to client to client aggression/abuse, staff to client aggression/abuse, and/or injuries of unknown origin."</p> <p>Corrective Action(s):</p> <p>To ensure that established agency policies and procedures for investigations are being implemented, corrective measures/actions are being implemented and executed as written in regard to retraining staff for all clients. To ensure that established agency policies and procedures for conducting thorough investigations are being implemented for all allegations of abuse, neglect and/or injuries of unknown source.</p> <p>1. All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. All investigations include appropriate corrective action and that all corrective actions/measures are implemented in regards to retraining staff for clients. To</p>	04/06/2016			

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	<p>[client #4] could not tell them where the bruise came from. [Staff #1] stated she did not know if [client #4] had done something at workshop that would have caused the bruise, or if it was from the bra she was wearing." The investigation indicated staff #1, staff #2, and the client were interviewed during the investigation. The investigation did not indicate any other staff including workshop staff were interviewed.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if the workshop staff had been interviewed in regard to client #4's bruise, RD stated "I can't answer that. My guess would be no." The facility did not provide further interviews to review.</p> <p>2. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 2/23/16 at 1:35pm. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations indicated the following (not all inclusive):</p> <p>Client #2's 5/28/15 accident report indicated client #2 was "assaulted by [client #3] who punched him multiple</p>		<p>ensure that all correctiveactions/measures are implemented, a Record of Training form will be completedfor all trainings on corrective actions/measures for the corrective and besubmitted to the Social Service Coordinator for review. The Social ServiceCoordinator will take a copy of the Record of training completed for thetraining and attached it to the investigation to ensure completion.</p> <p>Theinvestigations will be reviewed weekly by the Residential Director to ensuretrainings have been completed in accordance to the implemented correctiveactions/measures.</p> <p>2. Toensure that all investigations are conducted in a uniform and consistentmanner, all Residential House Managers, Qualified Individual DisabilitiesProfessionals, Nurses, Residential Director of Quality Assurance and SocialService Coordinator, and the Social Service Coordinator will be trained on thenewly established investigation process. Record of Training forms will becompleted following staff trainings and will be submitted to the ResidentialDirector for administrative oversight.</p> <p>3. Allstaff located in the home will be retrained on reportable incidents, theprocedure for reporting, and the abuse, neglect, and exploitation policy. Recordof</p>	

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	<p>times in the right side of his head. [Client #2] had reddening of the skin on the right side of his head and complained of a headache." The 6/2/15 investigation in regards to the client to client abuse indicated "[Client #3] stated he hit [client #2] because he was trying to help [client #5] get buckled, but [client #2] was already helping her and he got mad." The investigation indicated both clients #2 and #3 were interviewed. The investigation did not indicate client #5 was interviewed.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if client #5 was interviewed during the client to client abuse investigation, the RD stated "No."</p> <p>3. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 2/23/16 at 1:35pm. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations indicated the following (not all inclusive):</p> <p>Client #3's 7/27/15 accident report indicated "[Client #3] was walking up the ramp to the porch and tripped over a</p>		<p>Training forms will be completed following staff trainings and will besubmitted to the Residential Director for administrative oversight.</p>				

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	<p>loose board." The 7/31/15 investigation in regards to this fall indicated staff # 7 stated "[Client #3] was wearing his gait belt when the incident occurred, and that the gait belt was being properly used at the time of the incident." The investigation did not indicate how the fall happened if staff was properly holding onto his gait belt.</p> <p>Client #3's 7/10/15 reportable incident report indicated "[client #3] was walking inside the group home and lost his balance and fell onto his left knee." The 7/17/15 investigation in regards to this fall indicated staff #4 stated "[client #3] was walking from the kitchen to the dining room to put his bowl on the table so he could go outside and smoke. He stated [client #3] was walking too fast and lost his balance, which caused him to fall. He stated when he heard [client #3] fall he got up and helped assist him to standing back up. He stated [client #3's] fall plan was being followed at the time of the fall. He stated [client #3] was wearing his gait belt, and staff were properly using the gait belt at the time of the fall." The investigation did not indicate who was walking with client #3 holding his gait belt when he fell or how he fell if staff were holding his gait belt properly.</p>			

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	<p>Client #3's 8/4/15 reportable incident report indicated "[Client #3] was walking in the dining room at the group home when he lost his balance and fell." The 8/19/15 investigation in regards to this fall indicated staff #9 stated " [Client #3] was wearing his gait belt at the time of the fall, however, she stated she was not using it because she did not have to help him up." The investigation did not indicate who was walking with Client #3 and if staff #9 understood how to use client #3's gait belt.</p> <p>Client #3's 8/6/15 reportable incident report indicated "[Client #3] was on his way outside to smoke at the group home when he lost his balance and fell." The 8/19/15 investigation indicated staff #9 stated "[Client #3] was wearing his gait belt, however, staff did not use it at the time of the fall." The investigation did not indicate why staff was not using the gait belt in accordance to his falling management plan.</p> <p>Client #3's 8/18/15 reportable incident report indicated "[Client #3] was walking outside to the back porch at the group home when he lost his balance and fell." The 8/20/15 investigation in regards to this fall indicated staff #10 stated "[Client #3] was able to get back up on his own," and "[Client #3] was wearing his gait belt</p>			

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	<p>and the time of the fall." The investigation did not indicate who was holding onto client #3's gait belt and how he fell if his gait belt was being held onto.</p> <p>Client #3's 10/16/15 reportable incident report indicated "[Client #3] was walking in the living room at the group home when he fell." The 10/20/15 investigation in regards to this fall indicated staff in the home at the time of the fall reported they were not using the gait belt because "he was just walking around the home." The investigation did not indicate why staff in the home were not following client #3's falling management plan in regards to using the gait belt.</p> <p>Client #3 11/15/15 reportable incident report indicated "[Client #3] fell forward." The 12/8/15 investigation in regards to this fall indicated staff #7 stated "[Client #3] was trying to step over a concrete thing that was in front of where the van was parked when he tripped and fell. [Client #3] was wearing his gait belt at the time of the fall, however, he stated he was not utilizing the gait belt due to helping another consumer." The investigation did not indicate why client #3 was not being assisted with walking into the group</p>			

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	<p>home.</p> <p>Client #3's record was reviewed on 2/26/16 at 11:12am. Client #3's 11/18/15 falling management plan indicated "Direct Support Professionals will assist [client #3] by holding onto his gait belt when ambulating."</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if client #3's falls were investigated as allegations of neglect due to staff not utilizing client #3's gait belt as outlined in the falling management plan, the RD stated "No, we didn't look at it that way."</p> <p>9-3-2(a)</p>						
W 0157 Bldg. 00	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, interview and record review for 7 of 53 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to implement corrective action in regards to</p>	W 0157	<p>W157 Finding(s): 1. "Based on interview and record review for 7 of 53 allegations of abuse, neglect and/or injuries of unknown</p>	04/06/2016			

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	<p>not following client #3's falling management plan at the time a fall occurred.</p> <p>Findings include:</p> <p>During the 2/23/16 observation period between 4:00pm and 6:00pm and the 2/24/16 observation between 6:00am and 8:00am, client #3 was walking with a side to side gait. During two different occasions client #3 almost fell. Client #3 did have his gait belt on but staff present during the observations did not use the gait belt to assist client #3 with walking. Client #3 did have his knee pads on but did not have elbow pads or a walking stick.</p> <p>The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 2/23/16 at 1:35pm. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations indicated the following (not all inclusive):</p> <p>Client #3's 7/27/15 accident report indicated "[Client #3] was walking up the ramp to the porch and tripped over a loose board." The 7/31/15 investigation in regards to this fall indicated staff # 7 stated "[Client #3] was wearing his gait</p>		<p>source reviewed, the facility failed to ensure the facility put corrective actions/measures inplace."</p> <p>CorrectiveAction(s): Toensure that established agency policies and procedures for investigations arebeing implemented, corrective measures/actions are being implemented andexecuted as written in regard to retraining staff for all clients. To ensurethat established agency policies and procedures for conducting thoroughinvestigations are being implemented for all allegations of abuse, neglectand/or injuries of unknown source.</p> <p>1.Allinvestigations will be conducted in the manner outlined on the ResidentialServices Investigation Process. All investigations include appropriatecorrective action and that all corrective actions/measures are implemented inregards to retraining staff for clients. To ensure that all correctiveactions/measures are implemented, a Record of Training form will be completedfor all trainings on corrective actions/measures for the corrective and besubmitted to the Social Service Coordinator for</p>				

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	<p>belt when the incident occurred, and that the gait belt was being properly used at the time of the incident." The investigation did not indicate how the fall happened if staff was properly holding onto his gait belt. The investigation did not indicate if staff were retrained on client #3's falling management plan and the proper use of his gait belt.</p> <p>Client #3's 7/10/15 reportable incident report indicated "[client #3] was walking inside the group home and lost his balance and fell onto his left knee." The 7/17/15 investigation in regards to this fall indicated staff #4 stated "[client #3] was walking from the kitchen to the dining room to put his bowl on the table so he could go outside and smoke. He stated [client #3] was walking too fast and lost his balance, which caused him to fall. He stated when he heard [client #3] fall he got up and helped assist him to standing back up. He stated [client #3]'s fall plan was being followed at the time of the fall. He stated [client #3] was wearing his gait belt, and staff were properly using the gait belt at the time of the fall." The investigation did not indicate who was walking with client #3 holding his gait belt when he fell or how he fell if staff were holding his gait belt properly. The investigation did not indicate if staff were retrained on client</p>		<p>review. The Social Service Coordinator will take a copy of the Record of training completed for the training and attached it to the investigation to ensure completion. The investigations will be reviewed weekly by the Residential Director to ensure trainings have been completed in accordance to the implemented corrective actions/measures.</p> <p>2. To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Individual Disabilities Professionals, Nurses, Residential Director of Quality Assurance and Social Service Coordinator, and the Social Service Coordinator will be trained on the newly established investigation process. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>3. The Social Service Coordinator will not file any investigation until a Record of Training is turned in by the staff that provided the training. The Social Service Coordinator, the Assistant Director, and the Director will meet weekly to discuss corrective measures on investigations and monitor that the corrective action has been completed for administrative oversight.</p>		

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	<p>#3's falling management plan and the proper use of his gait belt.</p> <p>Client #3's 8/4/15 reportable incident report indicated "[Client #3] was walking in the dining room at the group home when he lost his balance and fell." The 8/19/15 investigation in regards to this fall indicated staff #9 stated "[Client #3] was wearing his gait belt at the time of the fall, however, she stated she was not using it because she did not have to help him up." The investigation did not indicate who was walking with Client #3 and if staff #9 understood how to use client #3's gait belt. The investigation did not indicate if staff were retrained on client #3's falling management plan and the proper use of his gait belt.</p> <p>Client #3's 8/6/15 reportable incident report indicated "[Client #3] was on his way outside to smoke at the group home when he lost his balance and fell." The 8/19/15 investigation indicated staff #9 stated "[Client #3] was wearing his gait belt, however, staff did not use it at the time of the fall." The investigation did not indicate why staff was not using the gait belt in accordance to his falling management plan. The investigation did not indicate if staff were retrained on client #3's falling management plan and the proper use of his gait belt.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2016
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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	<p>Client #3's 8/18/15 reportable incident report indicated "[Client #3] was walking outside to the back porch at the group home when he lost his balance and fell." The 8/20/15 investigation in regards to this fall indicated staff #10 stated "[Client #3] was able to get back up on his own," and "[Client #3] was wearing his gait belt and the time of the fall." The investigation did not indicate who was holding onto client #3's gait belt and how he fell if his gait belt was being held onto. The investigation did not indicate if staff were retrained on client #3's falling management plan and the proper use of his gait belt.</p> <p>Client #3's 10/16/15 reportable incident report indicated "[Client #3] was walking in the living room at the group home when he fell." The 10/20/15 investigation in regards to this fall indicated staff in the home at the time of the fall reported they were not using the gait belt because "he was just walking around the home." The investigation did not indicate why staff in the home were not following client #3's falling management plan in regards to using the gait belt. The investigation did not indicate if staff were retrained on client #3's falling management plan and the proper use of his gait belt.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2016
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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	<p>Client #3's 11/15/15 reportable incident report indicated "[Client #3] fell forward." The 12/8/15 investigation in regards to this fall indicated staff #7 stated "[Client #3] was trying to step over a concrete thing that was in front of where the van was parked when he tripped and fell. [Client #3] was wearing his gait belt at the time of the fall, however, he stated he was not utilizing the gait belt due to helping another consumer." The investigation did not indicate why client #3 was not being assisted with walking into the group home. The investigation did not indicate if staff were retrained on client #3's falling management plan and the proper use of his gait belt.</p> <p>Client #3's record was reviewed on 2/26/16 at 11:12am. Client #3's 11/18/15 falling management plan indicated "Direct Support Professionals will assist [client #3] by holding onto his gait belt when ambulating."</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if staff were retrained on client #3's falling management plan, the RD stated "It was in December." The facility was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/07/2016	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901			
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W 0159 Bldg. 00	<p>unable to provide any additional trainings for review. When asked if any corrective measures were put into place regarding staff not properly using client #3's gait belt, the RD stated "No."</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 observation, interview and record review for 3 of 4 sampled clients (#2, #3, and #4) the Qualified Intellectual Disabilities Professional (QIDP) failed to monitor clients' Individual Support Plans (ISPs) in regard to implementation and program development. The QIDP failed to coordinate clients' programs in regard to ensuring the clients who acted as their own guardian approved their restrictive programs. The QIDP failed to coordinate/obtain recommended adaptive equipment. The QIDP failed to ensure a client's interdisciplinary team (IDT) met and and/or addressed the effectiveness of client #4's suicide prevention plan.</p> <p>Findings include:</p>	W 0159	<p>W159 Finding(s): 1. "Based on observation, interview and record review for 3 of 4 sample clients (#2, #3 and #4), the Qualified Intellectual Disabilities Professional failed to monitor clients' Individual Support Plans in regard to implementation and program development."</p> <p>Corrective Action(s): To ensure clients #2, #3 and #4's Individual Support Plans are being implemented through formal and informal programming.</p> <p>1. The Qualified Intellectual Disabilities Professional (QIDP) completes a monthly report that monitors and evaluates the</p>	04/06/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/07/2016	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901			
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	<p>1. During the 2/23/16 observation period between 4:00pm and 6:00pm and the 2/24/16 observation period between 6:00am and 7:45am in the group home, clients were not assisting staff with meal prep. On 2/23/16 at 4:00pm chili was already cooked in the crockpot. At 4:32pm staff #1 was in the kitchen cutting up apples for the meal. Staff #1 did not ask clients to help her and there were no clients in the kitchen at this time.</p> <p>On 2/24/16 clients were having scrambled eggs or cereal for breakfast. Staff #4 was cracking eggs and whisking them. There were no clients in the kitchen with staff #4 at this time. At 6:15am staff #4 heated up a skillet and scrambled the eggs while clients gathered around the table waiting. At 6:25am staff #4 brought a bowl of eggs to the table.</p> <p>Client #2's record was reviewed on 2/25/16 at 2:19pm. Client #2's 5/24/15 ISP indicated client #2 had a formal training objective to "Gather all needed items for a recipe with one or less verbal prompt."</p> <p>Client #3's record was reviewed on 2/26/16 at 11:12am. Client #3's 6/12/15 ISP indicated client #3 had a formal training objective to "Prepare or bake a</p>		<p>formal and informal programming goals aswritten in the Individual Support Plan (ISP). The QIDP submits this report tothe Residential Director monthly for additional administrative oversight.</p> <p>2.The QIDP will ensure that every 3months of a refusal, mastering a goal as written, or achieving the same outcomethen an IDT meeting will be held to discuss revisions of the Informal andformal programs. The QIDP will revise the ISP as needed when revisions havebeen made to the program goals. All staff located in the home will be trainedon any revisions made to the ISP's. All record of trainings will be completedfollowing staff trainings and will be submitted to the Residential Director foradministrative oversight.</p> <p>3.The Residential House Manager and TheResidential Lead Direct Support Professional will observe staff weekly toensure they are implementing informal and/or formal programs through usingteachable moments through active treatment.</p> <p>1. "The Qualified Intellectual Disabilities Professional (QIDP) failed to coordinate clients' programs in regard to ensuring the clients who acted as their own guardian approved their restrictive programs. Corrective Action(s): The Qualified Individual</p>				

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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901			
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	<p>side dish following the recipe with 3 or less verbal prompts."</p> <p>Client #4's record was reviewed on 2/26/16 at 3:03pm. Client #4's 4/8/15 ISP indicated client #4 had a formal training objective to "Follow directions to cook a food item with 1 or less verbal prompts."</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if clients should be participating in meal preparation, the RD stated "Yes".</p> <p>2. Client #3's record was reviewed on 2/26/16 at 11:12am. Client #3's February 2016 BSP (Behavior Support plan) indicated client #3 had the following behaviors with restrictive interventions in place: Property destruction- "If attempts for redirection are not successful and [client #3] or someone else is being harmed HRC (Human Rights Committee) approved 2 person CPI (Crisis Prevention Intervention) will be used on [client #3]". Client #3's BSP indicated client #3 had restricted access to his lighters and used door and window alarms for elopement behaviors.</p> <p>Client #3's 6/12/15 ISP (Individualized</p>		<p>Disabilities Professional (QIDP) will ensure that allclients that act as their own guardian give written consent for all restrictiveprograms.</p> <p>1. TheQualifies Intellectual Disabilities Professional (QIDP) will obtain written informedconsent for all restrictive programs from all clients that reside in the GroupHome. The QIDP will ensure that at the Quarterly Human Rights Committee reviewsthat written informed consent is obtained by all clients that reside in thegroup home. The QIDP will obtain written informed consent whenever there arechanges made to any restrictive programs the client has.</p> <p>2. TheAssistant Director will do a Periodic Service Review quarterly and will ensurethat written informed consent is obtained for all restrictive programs to showadministrative oversight and monitoring.</p> <p>3. Allquarterly HRC approvals will be submitted to the Residential Director for reviewfor additional administrative over sight.</p> <p>1. "The Qualified IndividualDisabilities Professional (QIDP) failed to ensure a client's InterdisciplinaryTeam (IDT) met and/or addressed the</p>				

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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901		
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	<p>Support Plan) indicated client #3 was his own legal guardian.</p> <p>Client #3's record did not indicate client #3 gave written informed consent for his BSP that included restrictive programs.</p> <p>Client #4's record was reviewed on 2/26/16 at 3:03pm. Client #4's Feb 2016 BSP (Behavior Support Plan) indicated client #4 had the following targeted behaviors: self-injurious behavior, PICA (eating inedible objects), suicidal ideation/attempts, self-deprecating talk, elopement, and giving away items. Client #4's BSP indicated client #4 had the following restrictions in her plan: The use of CPI (Crisis Prevention Intervention), windows and door alarms on all doors, line of sight supervision, at day services staff will check before and after her shift to assure she doesn't have any unapproved items on her, personal razors to be locked up, all personal hygiene items are locked up and given to her in single use portions, no shoes with removable laces, no cords on the window blinds in her room, and if on safety watch she will be supervised while using the restroom and taking a shower to assure she doesn't ingest the soap or engage in self-injurious behaviors.</p> <p>Client #4's Feb 2016 BSP indicated client</p>		<p>effectiveness of client #4's Suicide Prevention Risk Plan."</p> <p>CorrectiveAction(s):</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) will ensure that an Interdisciplinary Team meeting is held for client #4 to address the effectiveness of her Suicide Prevention Risk Plan.</p> <p>1. The Qualified Intellectual Disabilities Professional will hold an Interdisciplinary Team meeting (IDT) to address Client #4's suicide prevention risk plan and its effectiveness.</p> <p>2. The Qualified Intellectual will make any changes to client #4's Suicide Prevention Risk Plan as determined by the Interdisciplinary team (IDT) and submit the revisions to the Residential Director for review.</p> <p>3. The Qualified Intellectual Disabilities Professional (QIDP) will train all staff located in the home on all revisions made for client #4's suicide prevention risk plan. All record of trainings will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p>		

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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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	<p>#4 was her own legal guardian.</p> <p>Client #4's record did not indicate client #4 gave written informed consent for her BSP that included restrictive programs.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if clients #3 and #4 gave written informed consent for their restrictive programs, the QIDP stated "We have talked to them and they agreed to their plans, but they didn't sign anywhere."</p> <p>3. During the 2/23/16 observation period between 4:00pm and 6:00pm and the 2/24/16 observation between 6:00am and 8:00am, client #3 was walking with a side to side gait. During two different occasions client #3 almost fell. Client #3 did have his gait belt on but staff present during the observations did not use the gait belt to assist client #3 with walking. Client #3 did have his knee pads on but did not have elbow pads or a walking stick.</p> <p>Client #3's record was reviewed on 2/26/16 at 3:03pm. Client #3's 8/21/15 physicians statement indicated client #3 was seen for a physical therapy evaluation to be evaluated due to falls.</p>			

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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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	<p>The physicians statement indicated "We need to get [client #3] a walking stick that he would use safely. Look at knee pads/wrist pads for safety to prevent fractures."</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if client #3 should use a walking stick or elbow pads, the QIDP stated "He said he didn't want them." When asked if the team had conducted any IDT's (Interdisciplinary Team's) in regards to client #3's refusal to wear his elbow pads or use his walking stick and his continuous falls, the QIDP stated "We don't have anything on paper."</p> <p>4. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 2/23/16 at 1:35pm. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations indicated the following (not all inclusive):</p> <p>-The 1/28/16 reportable incident report indicated "A direct support professional went into [client #4's] bedroom at 12:45am on 1/28/16 to complete 15 minute checks. [Client #4] was awake</p>			

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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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	<p>when the DSP approached her bed, and [client #4] told staff that she had something around her neck. The DSP found a strip of fabric around her neck. The DSP immediately cut off the strip of fabric, assessed her for marks, counseled [client #4] on the incident and kept her within line of sight to ensure her safety. "</p> <p>Client #4's record was reviewed on 2/26/16 at 3:03pm. Client #4's Feb 2016 BSP (Behavior Support Plan) indicated client #4 had the following targeted behaviors: self-injurious behavior, PICA (eating inedible objects), suicidal ideation/attempts, self-deprecating talk, elopement, and giving away items. Client #4's BSP indicated she had 3 levels of safety watches. Green level indicated "[client #4] is at a low risk for suicide. She has been mentally healthy for 1 week. No suicidal ideation/attempts, no self-injury, no giving away items, no elopement, limited self-deprecating speech, no talk of state hospitals or son. " Yellow level indicated client #4 " talks about her son and going back to the state hospitals. [Client #4] has increased self-deprecating speech. She may say she is a bad person or the ' Tasmanian devil '. She may offer to give her items away. If 1 or less incident, she may be placed on green level. " Red level indicated " Behavior that warrants</p>			

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	<p>the initiation of a red level: suicidal ideation or attempt. She may or may not have auditory hallucinations. She may say 'I want to kill myself' or 'the devil told me I'm going to die'. Length of time: 1-12 weeks after incident." Client #4's BSP indicated the following restrictions while client #4 is on red level: "[client #4] will not be sent to day programming, staff will provide 1 on 1 line of sight supervision, [Client #4] cannot completely close bedroom door unless staff are in the room with her, and staff with supervise her in the restroom/shower."</p> <p>Client #4's record did not indicate the team met to discuss client #4's BSP and suicide attempt to assure that her safety levels were providing adequate support.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if the team had met regarding client #4's recent suicide attempt and discussed the effectiveness of client #4's safety levels, the RD stated "We have but we don't have any documentation for it."</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2016
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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W 0249 Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review of 3 of 4 sampled clients (#2, #3, and #4), the facility failed to implement the clients' Individual Support Plans (ISP) when formal and/or informal training opportunities existed and to implement client #3's falling management plan.</p> <p>Findings include:</p> <p>1. During the 2/23/16 observation period between 4:00pm and 6:00pm and the 2/24/16 observation period between 6:00am and 7:45am, in the group home, clients #2, #3 and #4 were not assisting staff with meal prep. On 2/23/16 at 4:00pm chili was already cooked in the crockpot. At 4:32pm staff #1 was in the kitchen cutting up apples for the meal. Staff #1 did not ask clients to help her</p>	W 0249	<p>W249 Finding(s):</p> <p>1. "Based on observation, interview and record review for 3 of 4 sample clients (#2, #3 and #4), the facility failed to implement the clients' Individual Support Plan (ISP) when formal and/or informal training opportunities existed and to implement client #3's falling Management risk plan."</p> <p>Corrective Action(s): To ensure clients #2, #3 and #4's formal and/or informal programming plans are being followed when opportunities exist and implement client #3's falling Management Risk Plan.</p> <p>1. All staff located in the home will be retrained on client #2, #3 and #4's informal and/or formal programs and implementing those programs through active treatment when training opportunities exist. All staff located in the home will be</p>	04/06/2016
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/07/2016	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901			
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	<p>and there were no clients in the kitchen at this time. On 2/24/16 clients were having scrambled eggs or cereal for breakfast. Staff #4 was cracking eggs and whisking them. There were no clients in the kitchen with staff #4 at this time. At 6:15am staff #4 heated up a skillet and scrambled the eggs while clients gathered around the table waiting. At 6:25am staff #4 brought a bowl of eggs to the table.</p> <p>Client #2's record was reviewed on 2/25/16 at 2:19pm. Client #2's 5/24/15 ISP indicated client #2 had a formal training objective to "Gather all needed items for a recipe with one or less verbal prompt."</p> <p>Client #3's record was reviewed on 2/26/16 at 11:12am. Client #3's 6/12/15 ISP indicated client #3 had a formal training objective to "Prepare or bake a side dish following the recipe with 3 or less verbal prompts."</p> <p>Client #4's record was reviewed on 2/26/16 at 3:03pm. Client #4's 4/8/15 ISP indicated client #4 had a formal training objective to "Follow directions to cook a food item with 1 or less verbal prompts."</p> <p>An interview with the RD (Residential</p>		<p>trained on client #3's Falling Management Risk Plan and how to implement the plan correctly as individualized for client #3's needs. All record of trainings will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>Were any other clients affected by the deficient practices? all persons served residing in the group home had their Individual Specific Plans evaluated and their program goals Changes and revisions were made as needed. All staff located in the home were trained on Any revisions or changes made All record of trainings will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight. How will the facility monitor the onsite observation to ensure compliance? The Residential House Manager and The Lead Direct Support Professional will observe all active treatment and programming in the homes to ensure that it is being completed and the program goals are specific and appropriate to the individual Any issues or concerns will be reported immediately to the Qualified Intellectual Disabilities Professional for review with the IDT</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/07/2016
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W 0257	<p>Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if clients should be participating in meal preparation, the RD stated "Yes".</p> <p>2. During the 2/23/16 observation period between 4:00pm and 6:00pm and the 2/24/16 observation period between 6:00am and 7:45am, in the group home, client #3 walked around his home unassisted by staff.</p> <p>Client #3's record was reviewed on 2/26/16 at 11:12am. Client #3's 11/18/15 falling management plan indicated "Direct Support Professionals will assist [client #3] by holding onto his gait belt when ambulating."</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if staff should be holding onto client #3's gait belt while he is walking, the RD stated "Yes".</p> <p>9-3-4(a)</p> <p>483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE</p>				

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Bldg. 00	<p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#3 and #4), the facility failed to monitor and change clients' formal objectives when clients were not progressing in their goals.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 2/26/16 at 11:12am. Client #3's monthly summaries indicated the following:</p> <p>- "I will take a shower daily, with 1 or less verbal prompt, 75% of the time for 30 sessions." Client #3's 2015 monthly summaries indicated client #3 did not achieve this goal in July at 68%, no monthly summary for August, September at 57%, October at 35% and December at 65%. Client #3's 2015 monthly summaries all indicated the writer "recommends continuation until the goal is met consistently". Client #3's monthly summaries did not indicate any adjustments were made to the objective.</p> <p>- "I will practice simple addition, with 2 or less verbal prompts, 100% of the time</p>	W 0257	<p>W257 Finding(s): 1. "Based on record review and interview for 2 of 4 sampled clients (#3 and #4), the facility failed to monitor and change clients' formal objectives when clients were not progressing in their goals."</p> <p>Corrective Action(s): To ensure client #3 and #4's Individual Support Plan objectives (formal goals) are revised when they have achieved or not progressed on those objectives.</p> <p>1. The Qualified Intellectual Disabilities Professional (QIDP) will review and revise client #3 and #4's Individual Support Plan Objectives that have been achieved or have not progressed in a 3 month time frame. The QIDP will train all staff located in the home on the revised objectives. All record of trainings will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>2. The Qualified Intellectual Disabilities Professional (QIDP) will monitor the Individual Support Plan objectives each month when</p>	04/06/2016			

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	<p>for 4 sessions." Client #3's 2015 monthly summaries indicated client #3 did not achieve this goal in July at 25%, no monthly summary for August, September at 63%, October at 63%, November at 25% and December at 65%. Client #3's 2015 monthly summaries all indicated the writer "recommends continuation until the goal is met consistently". Client #3's monthly summaries did not indicate any adjustments were made to the objective.</p> <p>- "I will dress in clean appropriate clothing, independently, 100% of the time for 30 sessions." Client #3's 2015 monthly summaries indicated client #3 did not achieve this goal in July at 97%, no monthly summary for August, October at 94%, November at 97% and December at 97%. Client #3's 2015 monthly summaries all indicated the writer "recommends continuation until the goal is met consistently". Client #3's monthly summaries did not indicate any adjustments were made to the objective.</p> <p>- "I will identify the reason to take Hydroxyzine (Vistaril), independently, 100% of the time for 30 sessions." Client #3's 2015 monthly summaries indicated client #3 did not achieve this goal in July at 90%, no monthly summary for August, September at 93%, November at 85%</p>		<p>completing the monthlies. If an objective has been met or no progression has been made for 3 months in a row the QIDP will meet with the Inner Disciplinary Team (IDT) to discuss new objectives to be implemented and then the QIDP will revise the Individual Support Plan objectives. All staff located in the home will be trained on all revisions made to plans. All record of trainings will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>3. The Residential House Manager and The Residential Lead Direct Support Professional will observe staff weekly to ensure they are implementing informal and/or formal programs through using teachable moments through active treatment.</p>		

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	<p>and December at 55%. Client #3's 2015 monthly summaries all indicated the writer "recommends continuation until the goal is met consistently". Client #3's monthly summaries did not indicate any adjustments were made to the objective.</p> <p>- "I will put away my clean clothes, independently, 75% of the time for 4 sessions." Client #3's 2015 monthly summaries indicated client #3 did not achieve this goal in September at 40%, October at 0%, November at 0% and December at 0%. Client #3's 2015 monthly summaries all indicated the writer "recommends continuation until the goal is met consistently". Client #3's monthly summaries did not indicate any adjustments were made to the objective.</p> <p>- "I will load or unload the dishwasher appropriately, with 2 or less verbal prompts, 100% of the time for 4 sessions." Client #3's 2015 monthly summaries indicated client #3 did not achieve this goal in July at 25%, no monthly summary for August, September at 50%, October at 50%, November at 60% and December at 75%. Client #3's 2015 monthly summaries all indicated the writer "recommends continuation until the goal is met consistently". Client #3's monthly summaries did not indicate any adjustments were made to the</p>			

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	<p>objective.</p> <p>Client #4's record was reviewed on 2/26/16 at 3:03pm. Client #4's monthly summaries indicated the following:</p> <p>- "I will wipe my nose or mouth, with 1 or less verbal prompt, 75% of the time for 30 sessions." Client #4's 2015 monthly summaries indicated client #4 did not achieve this goal in May at 55%, June at 57%, July 55%, No monthly summary for August, September at 41%, October at 35% and December at 13%. Client #4's 2015 monthly summaries all indicated the writer "recommends continuation until the goal is met consistently". Client #4's monthly summaries did not indicate any adjustments were made to the objective.</p> <p>- "I will review my budget account with staff, with 1 or less verbal prompt, 100% of the time for 4 sessions." Client #4's 2015 monthly summaries indicated client #4 did not achieve this goal in September at 25%, October at 75% and November at 50%. Client #4's 2015 monthly summaries all indicated the writer "recommends continuation until the goal is met consistently". Client #4's monthly summaries did not indicate any adjustments were made to the objective.</p>			

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	<p>- "I will identify the reason I take my Lithium, independently, 100% of the time for 30 sessions." Client #4's 2015 monthly summaries indicated client #4 did not achieve this goal in May at 55%, June at 80%, No monthly summary for August, September at 50%, October at 10%, November at 0% and December at 84%. Client #4's 2015 monthly summaries all indicated the writer "recommends continuation until the goal is met consistently". Client #4's monthly summaries did not indicate any adjustments were made to the objective.</p> <p>- "I will brush my teeth thoroughly, independently, 100% of the time for 60 sessions." Client #4's 2015 monthly summaries indicated client #4 did not achieve this goal in May for AM at 81% and PM at 97%, June for AM at 90% and PM at 80%, July for AM at 70%, No monthly summary for August, September for AM at 0% and PM at 23%, October for AM at 39% and PM at 42%, November for AM at 20% and PM at 30% and December for AM at 0% and PM at 58%. Client #4's 2015 monthly summaries all indicated the writer "recommends continuation until the goal is met consistently". Client #4's monthly summaries did not indicate any adjustments were made to the objective.</p>			

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	<p>- "I will floss my teeth with 1 or less verbal prompt 100% of the time for 60 sessions." Client #4's 2015 monthly summaries indicated client #4 did not achieve this goal in June for AM at 83% and PM at 60%, July for AM at 71% and PM at 35%, No monthly summary for August, September for AM at 77% and PM at 68%, October for AM at 84% and PM at 86%, November for AM at 47% and PM at 77% and December for AM at 48% and PM at 74%. Client #4's 2015 monthly summaries all indicated the writer "recommends continuation until the goal is met consistently". Client #4's monthly summaries did not indicate any adjustments were made to the objective.</p> <p>- "I will make a positive statement about myself, with 1 or less verbal prompt, 100% of the time for 30 sessions." Client #4's 2015 monthly summaries indicated client #4 did not achieve this goal in June at 97%, in July at 84%, No monthly summary for August, September at 64%, October at 97%, November at 83% and December at 87%. Client #4's 2015 monthly summaries all indicated the writer "recommends continuation until the goal is met consistently". Client #4's monthly summaries did not indicate any adjustments were made to the objective.</p> <p>- "I will perform a relaxation activity,</p>			

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W 0261 Bldg. 00	<p>with 1 or less verbal prompt, 100% of the time for 30 sessions." Client #4's 2015 monthly summaries indicated client #4 did not achieve this goal in May at 94%, June at 97%, in July at 90%, No monthly summary for August, September at 91%, and November at 90%. Client #4's 2015 monthly summaries all indicated the writer "recommends continuation until the goal is met consistently". Client #4's monthly summaries did not indicate any adjustments were made to the objective.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked when the QIDP should be making changes to goals, the RD stated "At their annual, or when they have achieved or not achieved a goal consistently."</p> <p>9-3-4(a)</p> <p>483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary</p>			

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	<p>practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.</p> <p>Based on interview and record review for 4 of 4 sampled clients (#1, #2, #3, and #4) and for 4 additional clients (#5, #6, #7, and #8), the facility failed to ensure a client participated in its Human Rights Committee (HRC) meetings.</p> <p>Findings include:</p> <p>The facility's HRC minutes for clients #1, #2, #3, #4, #5, #6, #7 and #8 were reviewed on 2/26/16 at 1:22pm. The facility HRC minutes indicated the facility had a monthly HRC meeting. The facility's HRC members list included 2 names of client members. The facility's HRC minutes did not include a client name on the attendance roster for any of the HRC meetings held between 2/24/15 and 1/26/2016.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked when the last time a client member of the HRC attended and participated in a meeting, the RD stated "It's been a minute."</p> <p>9-3-4(a)</p>	W 0261	<p>W261</p> <p>Finding(s):</p> <p>1. "Based on interview and record review for 4 of 4 sampled clients (#1, #2, #3, and #4) and for 4 additional clients (#5, #6, #7, and #8), the facility failed to ensure a client participated in its Human Rights Committee (HRC) meetings."</p> <p>Corrective Action(s):</p> <p>To ensure a client participates in all Human Rights Committee (HRC) meetings.</p> <p>1. The Qualified Intellectual Disabilities Professional will seek a client participant for the Human Rights Committee (HRC) meetings and ensure they attend those HRC meetings. The Residential Director, The Assistant Director, and the Executive Vice President will be in attendance for Human Rights Committee meetings and ensure there is a client participant that is attending for additional administrative monitoring and oversight.</p>	04/06/2016			

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W 0263 Bldg. 00	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>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 4 sampled clients (#3 and #4) with restrictive program plans, the facility failed to obtain written informed consent from the clients for their restrictive programs.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 2/26/16 at 11:12am. Client #3's February 2016 BSP (Behavior Support plan) indicated client #3 took the following medications for behavior control: Tegretol XR, Tenex, Zyprexa, Seroquel XR and Trazodone. Client #3's BSP had the following behaviors with restrictive interventions in place: Property destruction- "If attempts for redirection are not successful and [client #3] or someone else is being harmed HRC approved 2 person CPI (Crisis Prevention Intervention) will be used on [client #3]". Client #3's BSP indicated client #3 had restricted access to his lighters and used door and window alarms for elopement behaviors.</p> <p>Client #3's 6/12/15 ISP (Individualized Support Plan) indicated client #3 was his own legal guardian.</p>	W 0263	<p>W263</p> <p>Finding(s):</p> <p>1. "Based on interview and record review for 2of 4 sampled clients (#3 and #4), with restrictive programs, the facility failed to obtain written informed consent from the clients' legally sanctioned representatives and/or clients regarding the clients' restrictive programs."</p> <p>CorrectiveAction(s):</p> <p>Toensure that written informed consent is obtained from the legally sanctioned representatives and/or clients #1, #2, and #4 for their restrictive behaviorprograms.</p> <p>1. The Qualified Intellectual Disabilities Professional will ensure that for all restrictive behavior programs. HRC approval will be obtained on a quarterly basis or in an emergency basis when warranted. All quarterly HRC approvals will be submitted to the Residential</p>	04/06/2016			

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	<p>Client #3's record did not indicate client #3 gave written informed consent for his BSP that included restrictive programs.</p> <p>Client #4's record was reviewed on 2/26/16 at 3:03pm. Client #4's Feb 2016 BSP (Behavior Support Plan) indicated client #4 was on the following medications for behavior control: Clozaril and Lithium Carbonate. Client #4's BSP had the following targeted behaviors: self-injurious behavior, PICA (eating inedible objects), suicidal ideation/attempts, self-deprecating talk, elopement, and giving away items. Client #4's BSP indicated client #4 had the following restrictions in her plan: The use of CPI (Crisis Prevention Intervention), windows and door alarms on all doors, line of sight supervision, at day services staff will check before and after her shift to assure she doesn't have any unapproved items on her, personal razors to be locked up, all personal hygiene items are locked up and given to her in single use portions, no shoes with removable laces, no cords on the window blinds in her room, and if on safety watch she will be supervised while using the restroom and taking a shower to assure she doesn't ingest the soap or engage in self-injurious behaviors.</p> <p>Client #4's Feb 2016 BSP indicated client #4 was her own legal guardian.</p> <p>Client #4's record did not indicate client #4 gave written informed consent for her BSP that included restrictive programs.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if clients #3 and #4 gave written informed consent for their restrictive</p>		Director for review for additional administrative oversight.		

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W 0331 Bldg. 00	<p>programs, the QIDP stated "We have talked to them and they agreed to their plans, but they didn't sign anywhere."</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview for 2 of 4 sampled clients (#1 and #3), the facility's nursing staff failed to develop a pain management protocol for client #1 and his routine pain medication and failed to assure client #3 attended follow up PT (Physical Therapy) appointments due to increased falls.</p> <p>Findings include:</p> <p>1. During the 2/23/16 observation period between 4:00pm and 6:00pm and the 2/24/16 observation between 6:00am and 8:00am client #3 was walking with a side to side gait. During two different occasions client #3 almost fell. Client #3 did have his gait belt on but staff present during the observations did not use the gait belt to assist client #3 with walking.</p>			W 0331	<p>W331 Finding(s): 1. "Based on observation, record review, and interview for 2 of 4 sampled clients (#1 and #3) the facility's nursing staff failed to develop a pain management protocol for client #1 and his routine pain medication and failed to assure client #3 attended follow up Physical Therapy (PT) appointments due to increased falls."</p> <p>Corrective Action(s): The Residential Nurse develops and implements a pain management protocol for client #1 and his routine pain medication and assures that client #3 attends all doctor ordered Physical Therapy (PT) appointments. 1. The Residential Nurse will develop and implement a pain management protocol for client #1</p>		04/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2016
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	<p>The facility's BDDS (Bureau of Developmental Disability Services) reportables and/or investigations were reviewed on 2/23/16 at 1:35pm. The BDDS reportables and/or investigations indicated the following (not all inclusive):</p> <p>-3/15/15: "[Client #3] received a mark/scrape on his right knee an inch in length and a half inch in width when he tripped and fell in his home."</p> <p>-3/17/15: "[Client #3] received a red scrape 3/4 wide inch by 1 and a half inches long on his right knee when he tripped and fell."</p> <p>-4/9/15: "[Client #3] tripped over a cart at [name of grocery store]. When he tripped he received a scrape on his right shin and left knee."</p> <p>-4/19/15: "[Client #3] was walking to get his medication and fell in the living room. He received a red mark on his left elbow when he fell."</p> <p>-4/22/15: "[Client #3] fell while trying to go outside and smoke. When he fell he received a scrape on his left knee that measured 1 centimeter, and then he had a red mark on his right knee".</p>		<p>for his routine pain management medication. The Residential Nursewill ensure that client #3 attends all doctor recommended Physical Therapyappointments.</p> <p>2.All staff located in the home will be trained on client #1's pain management protocol for his routine pain medication.All record of trainings will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>How will the facility monitor to ensure compliance. The Lead Direct Support professional will monitor that these forms are being completed weekly. The Residential Nurse will monitor these forms on a weekly basis as well. Any issues or concerns the Residential Nurse will be notified immediately</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2016
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	-5/6/15: "[Client #3] was walking into [name of grocery store] with staff and he fell on the floor. He received a 3 centimeter red mark on his right knee when he fell."			
	-5/15/15: "[Client #3] was walking in from smoking and fell to his knees and arms. When he fell he received a 1 inch red mark on his arm."			
	-7/17/15: "[Client #3] was walking when he lost his balance and fell. When he fell onto his left knee, and received a red area that measured three inches by two and a half inches."			
	-7/31/15: "[Client #3] fell while walking up the ramp at the group home. When he fell he received reddening to his right knee."			
	-8/4/15: "[Client #3] was walking to the van at a fast pace and would not slow down. As a result of walking too fast he fell and hit his arm on the van. When he fell he received a 1 1/4 inch bruise on his right arm."			
	-8/7/15: "[Client #3] slipped on the wet floor at a convenience store and received a 0.75 inch long mark on his right forearm and a dime sized mark on his right knee."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2016
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	<p>8/11/15: "[Client #3] was on the back porch at his home when he lost his balance and fell. When he fell it caused a light red mark that was 1.5 inches by 1.5 inches to his right knee."</p> <p>-8/19/15: "[Client #3] was walking in the dining room and lost his balance and fell. When he fell he received a red surface abrasion that measured 1.5 inches in length on his elbow."</p> <p>-8/19/15: "[Client #3] was on his way outside to smoke when he lost his balance and fell. When he fell he received a 1/2 inch red scrape on his right knee."</p> <p>-8/20/15: "[Client #3] was walking out on the back deck to go smoke when he lost his balance and fell. When he fell he received a 1 inch surface scrape on his right wrist and a 3 inch scrape on his right arm."</p> <p>-9/11/15: "[Client #3] fell while walking into the kitchen. When he fell he received a red surface abrasion that measured 1/2 inch by 1/2 inch on his right knee."</p> <p>-9/23/15: "[Client #3] was walking into [name of store] when he tripped and fell</p>			

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	<p>to his knees. When he fell he received a scrape on his knees that measured 1 inch by 1 inch."</p> <p>-10/20/15: "[Client #3] was walking in the living room when he fell. When he fell he received a 1/2 inch by 1/2 inch scrape on his right knee."</p> <p>-10/20/15: "[Client #3] was walking on the front porch when he fell. When he fell he received two scrapes measuring 1/2 inch by 1/2 inch on his right knee and a red mark on his left knee."</p> <p>-10/29/15: "[Client #3] was walking in the kitchen and fell onto his knees. When he fell he received 1 inch by 1/2 inch scrape on his left knee."</p> <p>-12/8/15: "[Client #3] was out in the community with staff, when he saw another staff member and got overly excited. He then tripped and fell. When staff assessed him after the fall, they noticed a light scrape on his left knee."</p> <p>-12/8/15: "[Client #3] fell while walking to the van while on an outing with staff. When he fell he received a 1 inch scrape on his left knee."</p> <p>-12/15/15: "[Client #3] fell and lost his balance while at the group home. When</p>			

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	<p>he fell he received red surface scrape on his left knee that measured 1.5 inches by 1 inch."</p> <p>-1/26/16: "[Client #3] was very excited and lost his balance while walking through the home. When he fell he received a 1 inch surface scrape on his left knee."</p> <p>Client #3's record was reviewed on 2/26/16 at 11:12 am. Client #3's 11/18/15 falling management plan indicated "[Client #3] wears a doctor ordered gait belt at all times. Direct Support Providers will assist [client #3] by holding onto his gait belt when he is ambulating, especially for long distances, at the workshop, and in the community."</p> <p>Client #3's 8/21/15 physicians statement indicated client #3 was seen for a physical therapy evaluation to be evaluated due to falls. The physicians statement indicated "We need to get [client #3] a walking stick that he would use safely. Look at knee pads/wrist pads for safety to prevent fractures." The physicians statement indicated client #3 was to return in 1 week. Client #3's record did not indicate client #3 returned to physical therapy.</p> <p>An interview with the RD (Residential</p>			

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	<p>Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if client #3 followed up with his physical therapy appointments, the QIDP stated "I know he did, he went for 6 weeks. I'll get the papers." The facility was unable to provide further documentation for review.</p> <p>2. Client #1's record was reviewed on 2/25/16 at 3:32 pm. Client #1's 2/1/16 physician orders indicated client #1 has a diagnosis of Lumbago (chronic lower back pain) and took Naproxen (pain medication) 375mg (Milligrams) twice daily.</p> <p>Client #1's 11/4/15 falling management plan indicated "[Client #1] was diagnosed with Lumbago, chronic lower back pain, due to his car accident from 20 years ago. Client #1's falling management plan did not indicate client #1 was on Naproxen to help with his chronic pain. Client #1's record did not indicate client #1 had a pain management protocol in place for the use of a routine pain medication.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked why client #1 took Naproxen, the</p>			

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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901		
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W 0336 Bldg. 00	<p>QIDP stated "He has Lumbago." When asked if client #1 had a pain management protocol, the QIDP stated "not one specific for him."</p> <p>9-3-6(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 4 of 4 sample clients (#1, #2, #3, and #4), the facility failed to provide evidence of a quarterly nursing/health assessment for each of the clients.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/25/16 at 3:32pm. Client #1's record included nursing quarterly assessments completed on 2/19/16 and 5/28/15. Client #1's record indicated no nursing assessments available for review the the months of August 2015 and Nov 2015.</p> <p>Client #2's record was reviewed on 2/25/16 at 2:19pm. Client #2's record included nursing</p>	W 0336	<p>W336</p> <p>Finding(s):</p> <p>1. "Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to provide evidence of a quarterly nursing/health assessment for each of the clients."</p> <p>CorrectiveAction(s):</p> <p>TheResidential Nurse will complete and document a quarterly nursing/healthassessment for each client that resides in the group home.</p> <p>1. TheResidential Nurse will complete and document a quarterly nursing/healthassessment for</p>	04/06/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2016
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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W 0362 Bldg. 00	<p>quarterly assessments completed on 2/19/16 and 5/28/15. Client #2's record indicated no nursing assessments available for review the the months of August 2015 and Nov 2015.</p> <p>Client #3's record was reviewed on 2/26/16 at 11:12am. Client #3's record included nursing quarterly assessments completed on 2/19/16 and 5/28/15. Client #3's record indicated no nursing assessments available for review the the months of August 2015 and Nov 2015.</p> <p>Client #4's record was reviewed on 2/26/16 at 3:03pm. Client #4's record included nursing quarterly assessments completed on 2/19/16 and 5/28/15. Client #4's record indicated no nursing assessments available for review the the months of August 2015 and Nov 2015.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if the facility had completed nursing assessments for the months of August 2015 and November 2015, the RD stated "No we had to fire a nurse so they were not completed."</p> <p>9-3-6(a)</p> <p>483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on interview and record review for 4 of 4 sampled clients (#1, #2, #3, #4),</p>	W 0362	<p>every client in the group home.</p> <p>2.A new Residential nurse has been hired andis thoroughly being trained on all policy/procedures including quarterlynursing/health assessments. All record of trainings will be completedfollowing each training and will be submitted to the Residential Director foradministrative oversight.</p> <p>3.The Assistant Director will do a quarterlyPeriodic Service Review and ensure that the nursing/health assessments havebeen completed by The Residential Nurse for administrative oversight.</p> <p>W362 Finding(s): 1. "Based on record review</p>	04/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/07/2016	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901			
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	<p>the facility failed to obtain quarterly pharmacy reviews of clients' medications.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/25/16 at 3:32pm. Client #1's 2/1/16 physician orders indicated client #1 took routine medication for his health and behavior.</p> <p>Client #1's record indicated the facility only obtained 2 pharmacy reviews, 2/9/16 and 11/10/15, within the last year.</p> <p>Client #2's record was reviewed on 2/25/16 at 2:19pm. Client #2's 2/1/16 physician orders indicated client #2 took routine medication for his health and behavior.</p> <p>Client #2's record indicated the facility only obtained 2 pharmacy reviews, 2/9/16 and 11/10/15, within the last year.</p> <p>Client #3's record was reviewed on 2/26/16 at 11:12am. Client #3's 2/1/16 physician orders indicated client #3 took routine medication for his health and behavior.</p> <p>Client #3's record indicated the facility only obtained 2 pharmacy reviews, 2/9/16 and 11/10/15, within the last year.</p>		<p>and interview for 4 of 4 sampled clients (#1,#2, #3 and #4), the facility failed to obtain quarterly pharmacy reviews of clients' medications."</p> <p>CorrectiveAction(s): The facility will obtain quarterly pharmacy reviews of all clients' medications.</p> <p>1. The Residential Director will obtain quarterly pharmacy reviews for all clients' medications and ensure that copies are kept in the main office.</p>				

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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901		
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W 0436 Bldg. 00	<p>Client #4's record was reviewed on 2/26/16 at 3:03pm. Client #4's 2/4/16 physician orders indicated client #4 took routine medication for her health and behavior.</p> <p>Client #4's record indicated the facility only obtained 2 pharmacy reviews, 2/9/16 and 11/10/15, within the last year.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked if the facility had obtained pharmacy reviews prior to 11/10/15, the RD stated "No, we have not. We will just have to take the hit for that."</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, interview and record review for 1 of 4 sampled clients</p>	W 0436	<p>W436 Finding(s): 1. "Based on observation,</p>	04/06/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/07/2016
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	<p>(#3), the facility failed to provided client #3 with his recommended adaptive equipment.</p> <p>Findings include:</p> <p>During the 2/23/16 observation period between 4:00pm and 6:00pm and the 2/24/16 observation period between 6:00am and 7:45am in the group home, client #3 did not utilize wrist pads or a walking stick while ambulating in the group home.</p> <p>Client #3's record was reviewed on 2/26/16 at 11:12am. Client #3's 11/18/15 falling management plan indicated "[Client #3] wears a doctor ordered gait belt at all times. Direct Support Providers will assist [client #3] by holding onto his gait belt when he is ambulating, especially for long distances, at the workshop, and in the community."</p> <p>Client #3's 8/21/15 physicians statement indicated client #3 was seen for a physical therapy evaluation to be evaluated due to falls. The physicians statement indicated "We need to get [client #3] a walking stick that he would use safely. Look at knee pads/wrist pads for safety to prevent fractures."</p> <p>An interview with the RD (Residential</p>		<p>record review and interview for 1 of 4 sampled clients (#3), the facility failed to provide client #3 with his recommended adaptive equipment."</p> <p>CorrectiveAction(s): The facility will ensure that client #3 is provided all doctor ordered adaptive equipment and the adaptive equipment is being implemented as per the plans client #3 has and the doctor orders.</p> <p>1. The Qualified Intellectual Disabilities Professional will review client #3's plans for his adaptive equipment and ensure that they are being implemented the way they are written and as per doctor orders.</p> <p>2. The Qualified Intellectual Disabilities Professional (QIDP) will train all staff located in the home on client #3's plans for his adaptive equipment and the implementation of those plans. All record of trainings will be completed following each training and will be submitted to the Residential Director for administrative oversight.</p> <p>3. The Residential House Manager and the Lead Direct Support Professional will monitor the use of client #3's adaptive equipment on a weekly basis to ensure that staff are implementing the plans as written for additional staff oversight.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2016
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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	<p>Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/26/16 at 3:36pm. When asked why client #3 did not have a walking stick or his wrist pads, the QIDP stated "Because he said he didn't want them." When asked if the facility had any documentation discussing client #3's refusal to use adaptive equipment, QIDP stated "No".</p> <p>9-3-7(a)</p>			