STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/18/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a recertification and state licensure survey. Dates of Survey: June 4, 5, 9, and 18, 2014. Facility number: 012527 Provider number: 15G802 AIM number: 201024860 Surveyors: Amber Bloss, QIDP-TC Paula Eastmond, QIDP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed July 1, 2014 by Dotty Walton, QIDP.	W000000	**To ensure that all clients residing in the group setting do not receive further repercussions or ramifications following BDDS reportable incidents that occur in the home the following corrective actions will be implemented:** 1) The agency will assume that all residences in the home have been affected by the incident that occurred. Therefore, in the event that any such incidents should occur again, the Residential Services Department will contact the agency Behavioral Consultant to address the events. The Behavior Consultant will meet with each client to discuss said events. When all meetings have been completed, the Behavior Consultant will submit a report that will include who was present for meetings and what was discussed. Notations of these meetings will be place in all client files. If it is determined that further attention is needed, the Behavior Consultant will conduct follow-up meetings with affected clients and Qualified Developmental Disabilities Professional (QDDP). *Refer to Appendix M behavior consultation form to be implemented.* ***a. "How will the facility monitor to ensure continued compliance"*** **Corrective Action(s): To ensure proper and adequate monitoring of clients affected**	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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			by BDDS reportable incidents occurring in the group home setting, the following corrective actions will be implemented: 1) A process for utilizing behavior consultation services on-site will be implemented. This process will include step-by-step details outlining the staff responsible for specific actions. *Refer to Appendix N for behavior consultation request process*. 2) QDDP will train staff on behavior consultation request process. *Refer to Appendix O for Record of Training form to be used*. **W104/W149/W153** ***a. "How will the facility monitor to ensure compliance"*** **CorrectiveAction(s): Toensure staff compliance in all areas, the following corrective actions will beimplemented:** The Qualified Developmental DisabilitiesProfessional (QDDP) and Residential House Manager (RHM) will alternate workingvarious shifts in the home alongside direct support staff. If insufficiencies in level of care by staff are noted by theQDDP and/or RHM, the Director and Vice President of Residential	

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			Services willbe immediately notified. Upon notification, the Director and Vice President ofResidential Services will require all staff working in the home to be counseledand re-trained on agency and departmental policies and procedures. Alltrainings will be documented on agency Record of Training forms and retained bythe Residential Services Coordinator. **W455/W488** ***b. "What kind of onsite monitoring will be done to ensure compliance?"*** **CorrectiveAction(s): Toensure proper and adequate monitoring of staff, the following correctiveactions will be implemented:** The Director and Vice President of ResidentialServices will make regular unannounced visits to the home to monitor forcompliance. If any insufficiencies in levelof care by staff are noted, the Director and Vice President of ResidentialServices will	

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			require all staff working in the home to be counseled andre-trained on agency and departmental policies and procedures. All trainingswill be documented on agency Record of Training forms and retained by theResidential Services Coordinator.	
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 1 of 4 sampled clients (#3) and for 1 additional client (#6), the facility's governing body failed to exercise general policy, budget and operating direction over the facility to develop a policy and procedure in regards to clients making large purchases for the group home (common areas and/or outdoor area) to ensure the clients did not make purchases for items the group home should provide. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients' items purchased by clients were replaced and/or repaired when destroyed by another client during behavioral incidents.	W000104	**Corrective Action(s):** **To ensure the Residential Services Department exercises general policy over budgeting and operating direction, the following corrective actions will be implemented:** 1) The Vice President and Director of the Residential Services Department will collaboratively draft a departmental policy to reflect the appropriate use and allocation of client funds to ensure the following: a) that no residential or group home resident purchases items for the home that are to be provided by the agency; b) that all client rights are enforced and protected when clients choose to make purchases, both large and	07/18/2014

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	Findings include: During the 6/4/14 observation period between 4:00 PM and 6:20 PM, at the group home, staff #5 and clients #2, #3, #4 and #7 were sitting out back on patio furniture. The group home had 2 patio chairs and 2 matching footstools with the chairs. The group home had 2 gas grills in the back yard and patio furniture/chairs with footstools outside the kitchen door and 2 patio chairs on the front porch area of the group home. In the living room, the group home had 2 suede couches, 2 blue recliners, 2 brown leather recliners and a swivel rocker in a corner of the living room. During the 6/4/14 observation period, client #3 showed the surveyor his grill sitting in the back yard. Interview with client #3 on 6/4/14 at 5:40 PM stated his grill "was broke" as client #6 had a behavior and tore up the inside fixtures of his grill. Client #3 indicated the inside parts were found on the ground in the group home's back yard. Client #3 indicated his propane gas/container was being used on another grill which was purchased by another client who lived at the group home. Client #3 indicated facility staff cooked food for clients #1, #2, #3, #4, #5, #6, #7 and #8 on his grill when it worked. Client #3 indicated his gas grill had not been repaired and/or replaced as it could not longer be used.		small; c) that all purchases and spend-down allocations follow all applicable state and federal guidelines; and d) that procedures are implemented and enforced to replace items purchased that are damaged by fellow group home residents. 2) Upon Board of Director approval of this policy, the Vice President of Residential Services will train all Residential Services staff on this policy. Completed Record of Trainings will be obtained and submitted upon completion of training.	

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	Client #3 indicated he had purchased the patio furniture facility staff and other clients sat on at the back kitchen door and the chairs on the front porch. Client #3 indicated he had made these purchases about 2 years ago. Client #3 also indicated he had purchased the 2 couches in the living room, the 2 blue recliners and the swivel rocker in the living room. Client #3 indicated client #6 had broken the ottoman that came with the rocker. Interview with client #6 on 6/4/14 at 4:30 PM indicated client #7 had destroyed the client's coffee table in the living room. Client #6 indicated he had purchased the coffee table. Client #6 indicated client #7 destroyed the coffee table during a behavioral incident. Client #6 indicated client #7 went to pick up the lounge chair the client had purchased, but he (client #6) grabbed the chair from client #7 to keep the client from throwing/destroying the chair. Client #6 indicated he had purchased the 2 leather brown reclining lounge chairs for the living room in the group home. Client #6 stated "He (client #7) does not have any money to replace my coffee table." Client #3's financial records were reviewed on 6/5/14 at 1:45 PM. Client #3's financial records indicated client #3			

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	did not make any large purchases within the last year (6/13 to 6/14). Client #6's financial records were reviewed on 6/5/14 at 1:45 PM. Client #6's financial records indicated the client had not made any large purchases within the past year. Interview with the Director of Residential Services on 6/5/14 at 2:00 PM stated clients #3 and #6 had purchased the above mentioned furniture for the living room "a couple of years ago." The Director indicated clients #3 and #6 had not made any large purchases within the past year. The Director stated clients #3 and #6 had made the purchases due to "large spend downs from their back Social Security money." The Director indicated the clients wanted to make the purchases. The Director also stated the clients purchased the large furniture items to have when they moved out into a "waiver setting." The Director indicated she was aware client #6's grill was broken, and client #7 would need to repay the client to have the item (coffee table) fixed/replaced. The Director indicated she was not aware client #3's propane gas container was on the second grill in the back yard. The Director indicated she did not know who/which client bought			

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	the second gas grill. The Director indicated she did not think client #6 owned/purchased the second grill. The Director indicated the facility staff cooked food on the grills for clients #1, #2, #3, #4, #5, #6, #7 and #8. When asked if the facility had a written policy and procedure in regard to clients making large purchases for the group home/common areas, and/or to ensure how the clients would be reimbursed for items broken by other clients' behaviors, the Director indicated she would check to see if the facility had a policy in regard to clients using their funds to make large purchases for the group home, and/or how the clients would be reimbursed if purchased items were broken by another client. The Director did not provide a policy in regard to large purchases for the group home. 9-3-1(a)			
W000125	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.			

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	Based on record review and interview, the facility failed to ensure the rights of clients were protected for 3 of 4 sampled clients (#1, #2, and #4) and 3 additional clients (#5, #7 and #8) residing in the home. Findings include: On 6/9/14 at 1:45 PM, record review indicated Client #3's diagnoses included, but were not limited to, mild intellectual disabilities, impulse control disorder, and antisocial personality disorder. Client #3's ISP (Individual Support Plan) dated 10/23/13 included a BSP (Behavior Support Plan) dated October 2013 which indicated Client #3 had targeted behaviors of physical aggression, sexual aggression/inappropriate sexual touching/predatory like and grooming, false accusations/lying, stealing, activity refusals/resists supervision, going into unauthorized areas, and threatening others/verbal abuse. Client #3's BSP indicated "[Client #3] has a history of predatory like, grooming, and sexual aggression (sic) behavior. Sexual aggression includes any type of sexual contact with another person that is unwanted. [Client #3] has a history of targeting lower functioning individuals. Sexual aggression toward individuals such as touching or grabbing private parts	W000125	**To ensure the protection of client rights, the following corrective actions will be implemented:** 1) Effective June 24, 2014, Qualified Developmental Disabilities Professional (QDDP), presented to the Human Rights Committee (HRC) and requested to rescind the previous request to require all bedroom doors remain open during sleeping hours. Request was approved and all eight clients residing in the home now may close their bedroom doors as they choose. *Refer to Appendix A for signed and approved Human Rights Committee Review documentation.* 2) Effective June 24, 2014, to ensure adequate and appropriate monitoring of Client #3 while protecting the rights of the other clients residing in the home, Qualified Developmental Disabilities Professional (QDDP), requested Human Rights Committee approval for the use of bed alarms and door alarms. *Refer to Appendix A for signed and approved Human Rights Committee Review documentation*. 3) To ensure adequate and appropriate monitoring of Client #3 while protecting the rights of the other clients residing in the	07/18/2014

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	is also PA (physical aggression)." Client #3's ISP indicated a Human Rights Committee (HRC) Review dated 10/29/13. Client #3's HRC review indicated "Due to 2 incidents in the past 6 months of sexual misconduct allegations in the group home, we are asking approval that all group home residents' doors remain open overnight while they are sleeping. This is for everyone's safety, [Client #3] had his annual 10/23/2013." On 6/5/14 at 12:48 PM, record review indicated Client #1 had a ISP (Individual Support Plan) dated 9/6/13 which indicated no assessment which indicated Client #1 had an assessed need for his bedroom door to remain open overnight while sleeping. On 6/5/14 at 4:00 PM, record review indicated Client #2 had an ISP dated 11/5/13 which indicated Client #2 had no assessed need for his bedroom door to remain open overnight while sleeping. On 6/9/14 at 2:40 PM, record review indicated Client #4 had an ISP dated 7/16/13 which indicated Client #4 had no assessed need for his bedroom door to remain open overnight while sleeping.		home, the Vice President, Director, Qualified Developmental Disabilities Professional, and Residential House Manager worked in collaboration with agency maintenance staff to renovate open space on the lower level of the group home at 112 East Westmoreland to create an additional bedroom. This additional bedroom will enable Client #3 to be placed in a room of his room to ensure necessary protective measures are adequately placed to meet his needs.	

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	On 6/9/14 at 3:00 PM, record review indicated Client #5 had an ISP dated 6/4/13 which indicated no assessed need for his bedroom door to remain open throughout overnight. On 6/9/14 at 3:20 PM, record review indicated Client #7 had an ISP dated 10/21/13 which indicated no assessed need for his bedroom door to remain open throughout the night while asleep. On 6/9/14 at 3:45 PM, record review indicated Client #8 had an ISP dated 10/22/13 which indicated no assessed need for his bedroom door to remain open throughout the night while asleep. On 6/5/14 at 2:08 PM during an interview, the facility nurse indicated the group home left all the bedroom doors open because of a substantiated allegation of sexual abuse by Client #3. The nurse indicated facility staff were to do bed checks every 15 minutes through the night to ensure all client safety. The nurse stated the doors remained open only during the night and "the guys are okay" with it. On 6/9/14 at 1:47 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #6 was Client #3's			

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	roommate. The QIDP indicated Client #6's rights were restricted by his door being kept open throughout the night because he shared a room with Client #3. The QIDP indicated Client #1, #2, #4, #5, #7, and #8 were not assessed as requiring their bedroom doors left open throughout the night The QIDP indicated the facility felt the clients were safer from potential sexual abuse by leaving their doors open and 15 minutes bed checks throughout the night shift. The QIDP stated the facility "did not realize" they were unnecessarily restricting the rights of Clients #1, #2, #4, #5, #7, and #8 by leaving their bedroom doors open. The QIDP indicated she understood the facility should provide monitoring for Client #3 to ensure the safety of others while protecting the rights of others. 9-3-2(a)			
W000149	483.420(d)(1)			

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	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 interview and record review, the facility failed to develop and/or implement policy and procedures to prevent staff to client abuse (verbal abuse) for 2 of 4 sampled clients (#1, #2) for 2 of 15 allegations of abuse, neglect, and/or injuries of unknown origin reviewed. Based on interview and record review for 3 of 15 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to develop and/or implement policy and procedures to prevent client to client aggression/abuse for 1 of 4 sampled clients (#2) and 2 additional clients (#6, #7). Based on interview and record review, the facility failed to develop and/or implement policy and procedures to prevent neglect in regards to a major medication error for 1 of 4 sampled clients (#1). Findings include: 1a. The facility's reportable incident reports and/or investigations were reviewed on 6/4/14 at 11:49 AM. A	W000149	**To ensure that established agency policies and procedures for abuse and neglect are being implemented and executed as written, the following corrective actions will be implemented:** 1) All staff located at the location of 112 East Westmoreland (Westmoreland group home) will be re-trained on the agency policy: Prohibition of Violations of Individual Rights. *Refer to Appendix B for copy of policy.* Completed Record of Trainings will be obtained and submitted upon completion of training. *Refer to Appendix C for Record of Training form to be used.* 2) All staff located at the location of 112 East Westmoreland (Westmoreland group home) will be re-trained on the agency medication administration policy. *Refer to Appendix D for copy of policy.* Completed Record of Trainings will be obtained and submitted upon completion of training. *Refer to Appendix E for Record of Training form to be used.*	07/18/2014

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	5/16/14 reportable incident report indicated "Direct support professional (DSP) reported that DSP, [staff #9] was verbally aggressive in her interactions with the residents. [Staff #9] was suspended and an investigation was started. Through the investigation in interviewing the consumers in the home and all the staff it was discovered that her verbal aggression was directed individually towards [client #1]...." The facility's 5/14/14 investigation indicated facility staff reported the allegation of verbal abuse to the QIDP (Qualified Intellectual Disabilities Professional) on 5/12/14 and interviews were conducted on 5/13 and 5/14/14. The facility's 5/14/14 investigation indicated facility staffs' witness statements of 5/13/14 indicated they had concerns of staff #9 verbally abusing client #1. The facility did not report the initial allegation of abuse to state officials until 5/16/14. On 6/9/14 at 3:00 PM during an interview, the QIDP indicated when she went to the group home on 5/12/14, staff told her they had concerns of staff #9's interaction with the clients. The QIDP indicated no BDDS (Bureau of Developmental Disabilities Services)report was made at that time as			

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	no specific allegation was made. The QIDP indicated once she started an investigation, other staff indicated staff reported staff #9 was verbally abusive toward client #1. The QIDP indicated reporting the allegation to BDDS was late. 1b. The facility's reportable incident reports and/or investigations were reviewed on 6/4/14 at 11:49 AM. The facility's 12/24/13 reportable incident report indicated "Staff reported to QIDP that she had overheard an inappropriate conversation between staff member [staff #10] and consumer [client #2]. She stated that [staff #10] was overheard to say to [client #2] that 'My husband allows me to have boyfriends.' The reporting staff also reported that [staff #10] rubbed [client #2's] hand." The reportable incident report indicated staff #10 was suspended pending an investigation. The facility's 1/22/14 follow-up report indicated "An investigation was done and staff was suspended pending outcome. Statements were not substantiated and staff was brought back to work and moved to a different group home." The facility's 1/24/14 follow-up report indicated "...During the investigation it was discovered that information was only			

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	given to other employees and never discussed with the consumer. Consumer was interviewed and stated the same thing. The allegations that were made by another employee were unsubstantiated." The facility's 1/30/14 follow-up report indicated facility staff were trained on "...being professional and appropriate boundaries and communication between employees and consumers...." The facility's 12/27/13 typed paper indicated "The allegation was that she made the statement to him that her husband lets her have boyfriends as long as she doesn't go home with them or sleep with them. The allegation was that [client #2] hugged her and then was making kissing sounds/attempts on her neck. Also that she rubbed his hand in a way that appeared inappropriate." The 12/27/13 typed note indicated the questions which staff #10 were to be asked. The facility's investigation did not indicate any documentation/investigation/interviews conducted with other staff, client #2 and/or other clients. The facility's investigation did not include any results and/or recommendations. Interview with the Director of Residential Services, the Vice President (VP) of			

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	Residential Services and the Qualified Intellectual Disabilities Professional (QIDP) on 6/9/14 at 3:00 PM indicated staff #10 was moved to a different group home. The Director, VP and QIDP indicated the allegation of sexual abuse/inappropriate comments was investigated. The QIDP and the VP indicated the staff person and client #2 were interviewed. The VP and the QIDP indicated no additional interviews were conducted. The VP, the Director and/or the QIDP did not provide any additional documentation of an investigation. On 6/9/14 at 4:30 PM, the facility abuse/neglect policy titled "Prohibition of Violations of Individual Rights" (undated) indicated "...Bona Vista Programs strictly prohibits the abuse of any form, neglect, exploitation or mistreatment of an individual... ." The policy defined "Prohibited Practices" as "(3) Emotional/Verbal abuse including but not limited to communicating words or actions in a person's presence with an intent to: cause the individual to be in fear of retaliation; cause the individual to be placed in fear of confinement or restraint; cause the individual to experience emotional distress or humiliation... ." 2. The facility's reportable incident			

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	reports, internal Accident/Incident Reports (AIRs) and/or investigations were reviewed on 6/4/14 at 11:49 AM. The facility's reportable incident reports, AIRs and/or investigations indicated the following client to client aggression/abuse incidents: -5/27/14 "[Client #2] was agitated when he arrived to work regarding a situation at his home. Staff encouraged [client #2] to stay away from [client #7], who he was upset with. After break, [client #2] ran over and threw him (client #7) on to (sic) the ground. Staff quickly separated [clients #2 and #7]...." The reportable incident report indicated client #2 was suspended from the workshop. The reportable incident report also indicated "...Staff will continue to monitor [client #2] and [client #7]. [Client #2] has a BSP (Behavior Support Plan) in place that shows targeted behaviors of verbal aggression and physical aggression. Both reactive and proactive strategies will be followed." The facility's 5/27/14 reportable incident report did not indicate any additional information and/or investigation. -4/6/14 "[Client #6] got into a fight with another consumer and was scratched on...abdomen...." The 4/6/14 AIR indicated the aggression occurred at the			

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	workshop. The AIR did not indicate who the other client was. The 4/6/14 AIR did not indicate any additional documentation and/or investigation in regard to the client to client aggression/abuse incident. -2/16/14 "[Client #7] was attacked by another consumer while [client #7] was having a behavior...." The reportable incident report indicated client #7's left eye was swollen and red in an area of "about 1 centimeter." The 2/16/14 AIR indicated the incident occurred at the group home. The 2/16/14 AIR did not indicate/identify who the other client was. The facility's 2/16/14 AIR did not indicate any additional documentation and/or investigation in regard to the client to client aggression/abuse. Interview with the QIDP, the Director of Residential Services and/or the VP on 6/9/14 at 3:00 PM indicated the facility did not conduct investigations in regard to the above mentioned incidents of client to client abuse/aggression. The VP indicated the facility was in the process of conducting investigations as they had been cited in a different group home. The VP and the Director indicated the facility's owned workshop did not conduct investigations in regard to client to client abuse/aggression.			

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	On 6/9/14 at 4:30 PM, the facility abuse/neglect policy titled "Prohibition of Violations of Individual Rights" (undated) indicated "...Bona Vista Programs strictly prohibits the abuse of any form, neglect, exploitation or mistreatment of an individual... ." The policy defined abuse as "intentional willful infliction of physical injury... ." 3. The facility's reportable incident reports and/or investigations were reviewed on 6/4/14 at 11:49 AM. The facility's 4/11/14 reportable incident report indicated "[Client #1] received his morning medications and [client #2's] medications. [Client #1's] doctor was immediately contacted and he was taken to [name of hospital] emergency room to be evaluated and admitted to the hospital for a 24 hour observation. Direct support professionals making this error were immediately suspended and an investigation was started immediately. [Client #2] did get his correct morning medications...." The facility's 4/11/14 witness statement with staff #11 indicated staff #11 had preset the medications up as staff #11 had heard client #2 was up (awake). The 4/11/14 witness statement indicated "...I poked my head out of the door and [client			

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	#2] wasn't there so I put meds on the table. [Staff #12] came in and said that she could do meds and took them and asked if they were [client #1's]. I wasn't paying attention and nodded yes...Realized when [client #2] came in asking for meds that they weren't on the desk. I asked [staff #12] about them and realized that the meds she (staff #12) picked up out of the office were [client #2's] and not [client #1's]. I asked [staff #12] if she gave those meds to [client #1] and she said she had...." The 4/11/14 witness statement indicated client #1 received his morning medications and client #2's medications. A second 4/11/14 interview with staff #11 indicated staff #11 had preset up 3 clients' medications on 4/11/14. The facility's undated investigation Evidence sheet indicated the 2 morning staff (staff #11 and #12) and clients #2, #3 and #6 were interviewed. The facility's undated evidence sheet did not indicate any further documentation, investigation, conclusion and/or recommendations in regard to the medication error. Interview with the VP and the Director on 6/9/14 at 3:00 PM indicated client #1 was admitted to the hospital for observation. The director and the VP			

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	indicated an investigation had been conducted and both staff had been terminated. On 6/9/14 at 4:30 PM, the facility abuse/neglect policy titled "Prohibition of Violations of Individual Rights" (undated) indicated "...Bona Vista Programs strictly prohibits the abuse of any form, neglect, exploitation or mistreatment of an individual... ." The policy defined neglect as "failure to provide supervision, training, appropriate food medical care, or medical supervision to an individual." 9-3-2(a)			
W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported			

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	immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 3 out of 15 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to provide documentation an incident of elopement/neglect was reported to state officials. The facility failed to ensure staff immediately reported allegations of abuse to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 in accordance with state law for clients #1 and #4. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 6/4/14 at 11:49 AM. The facility's 9/15/13 reportable incident report indicated "On 9/17/13, DSP (Direct Support Professional), [staff #3] stated to his supervisor, [staff #2], that he was aware of (sic) medication error that occurred on 9/15/13 involving [client #1]. Per [staff #3], the 8:00 am medication Concerta was not passed. When the error was discovered, instead of following agency policy regarding medication errors, staff attempted to alter	W000153	**To ensure that established agency policies and procedures for incident reporting is being implemented and executed as written, the following corrective actions will be implemented:** 1) All staff located at the location of 112 East Westmoreland (Westmoreland group home) will be re-trained on the agency Personnel Policies and Procedures, Policy III:13: Incident Reporting. Completed Record of Trainings will be obtained and submitted upon completion of training. *Refer to Appendix F for Record of Training form to be used.*	07/18/2014

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	the documentation to hide the error. An investigation is currently being completed and all staff involved are not working in the home until the conclusion of the investigation and recommendation from APS. Supervisor learned of the incident 2 days after the missed medication...." The 9/15/13 reportable incident report indicated facility staff did not report the allegation of abuse/neglect to the administrator until 9/17/13. Interview with the Director of Residential Services and the Qualified Intellectual Disabilities Professional (QIDP) on 6/9/14 at 3:00 PM indicated they reported the allegation of abuse to BDDS once they were aware of the 9/15/13 incident on 9/17/13. 2. The facility's reportable incident reports and/or investigations were reviewed on 6/4/14 at 11:49 AM. The facility's 4/2/14 investigation indicated on 3/30/14, "[Client #4] was sitting at the kitchen table with 7 other housemates for lunch. Two direct support professionals were in the kitchen with the consumers preparing and serving lunch. At one point, they received a phone call from another group home stating that [client #4] was one house down sitting on the corner of [names of streets]. The door alarm was not heard. Direct support			

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	professional went and got [client #4] and he came back into the house. QDDP (Qualified Developmental Disabilities Professional) was notified and came to the home. An investigation was immediately started, both staff were suspended pending investigation. [Client #4] told QDDP he snuck out of the house quietly and turned the alarm off the door so no one would hear it. [Client #4] had no injuries from this incident. [Client #4] has an elopement risk plan. Door alarms will be set so that consumer is unable to turn them off. The approximate time [client #4] was unsupervised is for 5 minutes." The facility's 4/2/14 investigation indicated a BDDS report was "Submitted but not saved." Review of the facility's reportable incident reports from 1/14 to 6/14 indicated the facility did not report the allegation of neglect in regard to client #4's elopement as no documentation/BDDS report was provided. Interview with the QIDP on 6/9/14 at 3:00 PM indicated she would need to check to see when it was reported. An email dated 3/31/14 to a BDDS representative indicated the QIDP submitted an initial report on 3/31/14. The email indicated "...The database			

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	submitted it to you then kicked me off so I could not save or print. Is there anyway to get this emailed to me without knowing the incident report number?...." A 6/9/14 email from the QIDP indicated she did not receive a copy of the 3/30/14 reportable incident report from BDDS. 3. The facility's reportable incident reports and/or investigations were reviewed on 6/4/14 at 11:49 AM. A 5/16/14 reportable incident report indicated "Direct support professional reported that DSP, [staff #9] was verbally aggressive in her interactions with the residents. [Staff #9] was suspended and an investigation was started. Through the investigation in interviewing the consumers in the home and all the staff it was discovered that her verbal aggression was directed individually towards [client #1]...." The facility's 5/14/14 investigation indicated facility staff reported the allegation of verbal abuse to the QIDP on 5/12/14 and interviews were conducted on 5/13 and 5/14/14. The facility's 5/14/14 investigation indicated facility staffs' witness statements of 5/13/14 indicated they had concerns of staff #9 verbally abusing client #1. The facility did not report the initial allegation of abuse to state officials until 5/16/14.			

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	On 6/9/14 at 3:00 PM during an interview, the QIDP indicated when she went to the group home on 5/12/14, staff told her they had concerns of staff #9's interaction with the clients. The QIDP indicated no BDDS report was made at that time as no specific allegation was made. The QIDP indicated once she started an investigation, other staff indicated staff reported staff #9 was verbally abusive toward client #1. The QIDP indicated reporting the allegation of verbal abuse to BDDS was late. 9-3-2(a)			
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 6 of 15 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct investigations in regard to client to client aggression/abuse and/or to conduct thorough investigations in regard to allegations of abuse/neglect for clients #1, #2, #6 and #7.	W000154	**Corrective Action(s):** **To ensure that established agency policies and procedures for incident reporting is being implemented and executed as written, the following corrective actions will be implemented:**	07/18/2014

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	Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 6/4/14 at 11:49 AM. The facility's 12/24/13 reportable incident report indicated "Staff reported to QIDP (Qualified Intellectual Disabilities Professional) that she had overheard an inappropriate conversation between staff member [staff #10] and consumer [client #2]. She stated that [staff #10] was overheard to say to [client #2] that 'My husband allows me to have boyfriends.' The reporting staff also reported that [staff #10] rubbed [client #2's] hand." The reportable incident report indicated staff #10 was suspended pending an investigation. The facility's 1/22/14 follow-up report indicated "An investigation was done and staff was suspended pending outcome. Statements were not substantiated and staff was brought back to work and moved to a different group home." The facility's 1/24/14 follow-up report indicated "...During the investigation it was discovered that information was only given to other employees and never discussed with the consumer. Consumer was interviewed and stated the same		1) All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. *Refer to Appendix G for process outline.* To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Development Disability Professionals, Nurses, the Director, and the Residential Services Coordinator will be trained on the newly established investigation process outline. *Refer to Appendix H or Record of Training form to be used in documenting training*. 2) To ensure that all incidents of injury of unknown origin and peer-to-peer aggression are properly documented and investigated. Any incidents will be reported to the Residential Services Coordinator. The Residential Services Coordinator will complete the appropriate documentation and maintain for record keeping purposes. *Refer to Appendix I to review forms that will be implemented occurrences of either incident*. 3) Lastly to ensure that incidents have been reported and investigated in the manner as outlined in agency policies, all investigations packets, regardless of type, will have an investigation process checklist included. The checklist will be completed by the	

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	thing. The allegations that were made by another employee were unsubstantiated." The facility's 1/30/14 follow-up report indicated facility staff were trained on "...being professional and appropriate boundaries and communication between employees and consumers...." The facility's 12/27/13 typed paper indicated "The allegation was that she made the statement to him that her husband lets her have boyfriends as long as she doesn't go home with them or sleep with them. The allegation was that [client #2] hugged her and then was making kissing sounds/attempts on her neck. Also that she rubbed his hand in a way that appeared inappropriate." The 12/27/13 typed note indicated the questions which staff #10 was to be asked. The facility's investigation did not indicate any documentation/investigation/interviews conducted with other staff, client #2 and/or other clients. The facility's investigation did not include any results and/or recommendations. Interview with the Director of Residential Services, the Vice President (VP) of Residential Services and the Qualified Intellectual Disabilities Professional (QIDP) on 6/9/14 at 3:00 PM indicated		Residential Services Coordinator as he/she is conducting the investigation. Upon the conclusion of the investigation, all investigation materials including the checklist will be given to the Vice President of Residential Services for review. The Vice President of Residential Services will sign-off on the checklist and accompanying materials once all items have been reviewed and approved. *Refer to Appendix J to review investigation process checklist*.	

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	staff #10 was moved to a different group home. The Director, VP and QIDP indicated the allegation of sexual abuse/inappropriate comments was investigated. The QIDP and the VP indicated the staff person and client #2 were interviewed. The VP and the QIDP indicated no additional interviews were conducted. The VP, the Director and/or the QIDP did not provide any additional documentation of an investigation. 2. The facility's reportable incident reports and/or investigations were reviewed on 6/4/14 at 11:49 AM. The facility's 4/11/14 reportable incident report indicated "[Client #1] received his morning medications and [client #2's] medications. [Client #1's] doctor was immediately contacted and he was taken to [name of hospital] emergency room to be evaluated and admitted to the hospital for a 24 hour observation. Direct support professionals making this error were immediately suspended and an investigation was started immediately. [Client #2] did get his correct morning medications...." The facility's 4/11/14 witness statement with staff #11 indicated staff #11 had preset the medications up as staff #11 had heard client #2 was up. The 4/11/14 witness statement indicated "...I poked			

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	my head out of the door and [client #2] wasn't there so I put meds on the table. [Staff #12] came in and said that she could do meds and took them and asked if they were [client #1's]. I wasn't paying attention and nodded yes...Realized when [client #2] came in asking for meds that they weren't on the desk. I asked [staff #12] about them and realized that the meds she (staff #12) picked up out of the office were [client #2's] and not [client #1]. I asked [staff #12] if she gave those meds to [client #1] and she said she had...." The 4/11/14 witness statement indicated client #1 received his morning medications and client #2's medications. A second 4/11/14 interview with staff #11 indicated staff #11 had preset up 3 clients' medications on 4/11/14. The facility's undated investigation Evidence sheet indicated the 2 morning staff (staff #11 and #12) and clients #2, #3 and #6 were interviewed. The facility's undated evidence sheet did not indicate any further documentation, investigation, conclusion and/or recommendations in regard to the medication error. Interview with the VP and the Director on 6/9/14 at 3:00 PM indicated client #1 was admitted to the hospital for observation. The director and the VP			

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	indicated an investigation had been conducted and both staff had been terminated. 3. The facility's reportable incident reports, internal Accident/Incident Reports (AIRs) and/or investigations were reviewed on 6/4/14 at 11:49 AM. The facility's reportable incident reports, AIRs and/or investigations indicated the following client to client aggression/abuse incidents: -5/27/14 "[Client #2] was agitated when he arrived to work regarding a situation at his home. Staff encouraged [client #2] to stay away from [client #7], who he was upset with. After break, [client #2] ran over and threw him (client #7) on to the ground. Staff quickly separated [clients #2 and #7]...." The reportable incident report indicated client #2 was suspended from the workshop. The reportable incident report also indicated "...Staff will continue to monitor [client #2] and [client #7]. [Client #2] has a BSP (Behavior Support Plan) in place that shows targeted behaviors of verbal aggression and physical aggression. Both reactive and proactive strategies will be followed." The facility's 5/27/14 reportable incident report did not indicate any additional information and/or investigation.			

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	-4/6/14 "[Client #6] got into a fight with another consumer and was scratched on...abdomen...." The 4/6/14 AIR indicated the aggression occurred at the workshop. The AIR did not indicate who the other client was. The 4/6/14 AIR did not indicate any additional documentation and/or investigation in regard to the client to client aggression/abuse incident. -2/16/14 "[Client #7] was attacked by another consumer while [client #7] was having a behavior...." The reportable incident report indicated client #7's left eye was swollen and red in an area of "about 1 centimeter." The 2/16/14 AIR indicated the incident occurred at the group home. The 2/16/14 AIR did not indicate/identify who the other client was. The facility's 2/16/14 AIR did not indicate any additional documentation and/or investigation in regard to the client to client aggression/abuse. Interview with the QIDP, the Director of Residential Services and/or the VP on 6/9/14 at 3:00 PM indicated the facility did not conduct investigations in regard to the above mentioned incidents of client to client abuse/aggression. The VP indicated the facility was in the process of conducting investigations as they had			

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	been cited in a different group home. The VP and the Director indicated the facility's owned workshop did not conduct investigations in regard to client to client abuse/aggression. 9-3-2(a)			
W000159	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 record review and interview, the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate an IDT (interdisciplinary team) meeting to address the physician's recommendations for restrictive measures in regards to door and bed alarms for 1 of 4 sampled clients (#3). Based on record review and interview, the QIDP failed to address the Speech Therapist recommendation for outpatient speech therapy for 1 of 4 sampled clients (#4). Findings include: 1) On 6/4/14 at 11:45 AM, the facility	W000159	**Corrective Action(s): To ensure that established agency policies and procedures for incident reporting is being implemented and executed as written, the following corrective actions will be implemented:** 1) All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. *Refer to Appendix G for process outline.* To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Development Disability Professionals, Nurses, the Director, and the Residential Services Coordinator will be trained on the newly established investigation process outline.	07/18/2014

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	BDDS (Bureau of Developmental Disabilities Services) reports from 12/4/13 to 6/4/14 were reviewed. A BDDS report dated 5/12/14 indicated "[Client #4] woke up around 1:45 AM 5/12/14 and went into the kitchen. He told direct support professional that [Client #3] came into his room and was humping his bed. Direct support professionals immediately contacted QDDP (Qualified Developmental Disabilities Professional) and checked on [Client #3]. [Client #3] was asleep and snoring in his room. QDDP informed staff to sit in the chair facing the hall (where [Client #3] and [Client #4] bedrooms were) and watch the hall the rest of the night. [Client #4] was to be asked in the morning when he woke up what had happened and inform QDDP. ([Client #4] has a history of false allegation). When [Client #4] woke up he was asked and stated the same story." The BDDS report indicated "QDDP contacted Residential Director and Residential Vice President and an investigation was started. [Client #4] continued to change his story that morning to random people at the workshop. When interviewed by QDDP and a witness his story continued to change. [Client #4] was interviewed by QDDP, Residential Director, Residential Vice President, Residential nurse, the		*Refer to Appendix H or Record of Training form to be used in documenting training*. 2) To ensure that all incidents of injury of unknown origin and peer-to-peer aggression are properly documented and investigated. Any incidents will be reported to the Residential Services Coordinator. The Residential Services Coordinator will complete the appropriate documentation and maintain for record keeping purposes. *Refer to Appendix I to review forms that will be implemented occurrences of either incident*. 3) Lastly to ensure that incidents have been reported and investigated in the manner as outlined in agency policies, all investigations packets, regardless of type, will have an investigation process checklist included. The checklist will be completed by the Residential Services Coordinator as he/she is conducting the investigation. Upon the conclusion of the investigation, all investigation materials including the checklist will be given to the Vice President of Residential Services for review. The Vice President of Residential Services will sign-off on the checklist and accompanying materials once all items have been reviewed and approved. *Refer to Appendix J to review investigation process checklist*.	

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	attending physician at [Emergency Room], the SANE (Sexual Abuse Nurse Examiner), and (police officer)." The report indicated "medical assessment results from each party stated no trauma, no observation needed, nor any follow up required." The report indicated Client #3 "stated when he was interviewed that he was asleep all night in his room and never got up. [Client #3] was taken for a psychiatric appointment 5/12/14 and this allegation was discussed with [psychiatrist]. [Client #3] stated the same thing as prior that he slept through the night in his bed and did not get up." The BDDS report indicated staff would "continue to do bed checks every 15 minutes, all bedroom doors continue to remain open through sleep hours, continue to monitor for any changes needed to current implementations, continued to attend all psychiatric appointments, continue to follow BSP's (Behavior Support Plans), IDT (Interdisciplinary Team) meeting to be scheduled to discuss proactive measures to be taken for any future false allegations and incidents that could arise...". On 6/9/14 at 1:45 PM, record review indicated Client #3's diagnoses included, but were not limited to, mild intellectual disabilities, impulse control disorder, and			

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	antisocial personality disorder. Client #3's ISP (Individual Support Plan) dated 10/23/13 included a BSP (Behavior Support Plan) dated October 2013 which indicated Client #3 had targeted behaviors of physical aggression, sexual aggression/inappropriate sexual touching/predatory like and grooming, false accusations/lying, stealing, activity refusals/resists supervision, going into unauthorized areas, and threatening others/verbal abuse. Client #3's BSP indicated "[Client #3] has a history of predatory like, grooming, and sexual aggression behavior. Sexual aggression includes any type of sexual contact with another person that is unwanted. [Client #3] has a history of targeting lower functioning individuals. Sexual aggression toward individuals such as touching or grabbing private parts is also PA (physical aggression)." Client #3's ISP indicated a Human Rights Committee (HRC) Review dated 10/29/13. Client #3's HRC review indicated "Due to 2 incidents in the past 6 months of sexual misconduct allegations in the group home, we are asking approval that all group home residents' doors remain open overnight while they are sleeping. The is for everyone's safety, [Client #3] had his annual 10/23/2013."			

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	Record review indicated Client #3's "Psychiatrist Statement" dated 5/12/14 indicated the recommendation "suggest bed, door alarm, and consider video monitoring system of bedroom, if this doesn't help, would consider alternative placement." On 6/5/14 at 3:17 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated the BDDS (Bureau of Developmental Disabilities Services) report dated 5/12/14 regarding the sexual abuse allegation against Client #3 was unsubstantiated. The QIDP indicated she requested the psychiatrist make those recommendations of additional alarms and monitoring for Client #3's bedroom before the investigation indicated the allegation was unsubstantiated. The QIDP indicated because the allegation was unsubstantiated, the facility believed the safeguards (bedroom doors remaining open during sleeping hours with every 15 minute bed checks) were sufficient. The QIDP indicated members of Client #3's team discussed possible safeguards informally but there was no documentation to indicate an IDT (Interdisciplinary Team) meeting was held. The QIDP indicated no formal IDT meeting was held to discuss the psychiatrist's recommendations of bed			

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	alarm, door alarm, and possible video monitoring to prevent sexual abuse by Client #3. The QIDP indicated the IDT should have met to address the psychiatrist's recommendation. 2) On 6/9/14 at 2:40 PM, record review indicated Client #4's diagnosis, included but was not limited to, intellectual disabilities. An undated swallow study indicated a recommendation for "outpatient speech therapy." Client #4's ISP (Individual Support Plan) dated 7/6/13 indicated Client #4 did not receive outpatient speech therapy. On 6/5/14 at 3:17 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated she thought Client #4 had the swallow evaluation between 10/2013 and 11/2013 due to a decline in swallowing. The QIDP indicated Client #4 did not receive the outpatient speech therapy as recommended by the speech therapist. 9-3-3(a)			

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W000455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review, and interview, for 2 of 4 clients observed during medication administration (Clients #1 and #8), the facility failed to implement infection control practices during medication administration. Findings include: On 6/4/14 between 7:18 AM and 7:47 AM, group home medication administration was observed. At 7:18 AM, DSP (Direct Support Professional) #1 assisted Client #8 with morning medication administration. DSP #1 did not wash her hands or use alcohol gel prior to having administered a tablet of Risperidone 3 mg/milligrams, Divalproex 250mg tablet, Olanzapine 5mg tablet, and a tablet of Benztropine 1 mg by popping each tablet out of the bubble packet, into her bare hand, and into the medication cup. DSP #1 added applesauce to the medication cup and assisted Client #8 in taking his medication.	W000455	**Corrective Action(s):** **To ensure that established agency policies and procedures medication administration are being implemented and executed as written, the following corrective actions will be implemented:** **1)** All staff located at the location of 112 East Westmoreland (Westmoreland group home) will be re-trained on the agency medication administration policy. *Refer to Appendix D for copy of policy.* Completed Record of Trainings will be obtained and submitted upon completion of training. *Refer to Appendix E for Record of Training form to be used.*	07/18/2014

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	On 6/4/14 at 7:33 AM, DSP #1 assisted Client #1 with his medication administration. Client #1 did not wash his hands and DSP #1 did not prompt Client #1 to wash his hands prior to medication administration. DSP #1 assisted Client #1 with Ziprasidone 80mg (1/2 tablet), Lisinopril 10mg, Oxcarbazepine 600mg (1/2 tablet), Lamotrigine 200mg, Lithium 450mg, Divalproex ER (extended release) 500mg, Therapeutic M, and Methylphenidate 54mg. DSP #1 popped each of Client #1's tablets into her bare hand from the bubble packs and placed each into the medication cup. On 6/5/14 at 2:08 PM during an interview, the facility's nurse indicated it was not proper infection control for DSP #1 to have popped the tablets from the bubble packs into her bare hands before placing them into the medication cups for clients #1 and #8. The nurse indicated DSP #1 should have prompted Client #1 to wash his hands prior to medication administration for infection control. 9-3-7(a)			

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W000488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation 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 each client participated in all aspects of the meal preparation to the best of their abilities. Findings include: On 6/4/14 between 6:15 AM and 7:47 AM, group home observations were conducted. During breakfast, DSP (Direct Support Professional) #2 cooked eggs at the stove without the assistance of clients. DSP #2 brought Client #8 a plate of scrambled eggs with cheese to him while he sat at the dining room table. Client #1 prepared his own bagel and Client #5 made coffee independently. DSP #2 brought Client #4 a plate of scrambled eggs to the table without his assistance. During the 6/4/14 observation period between 4:00 PM and 6:10 PM, at the group home, staff #5 was standing in the kitchen putting lima beans on the stove to cook. Pork Chops were in the stove cooking with potatoes. No clients were	W000488	**To ensure that clients are encouraged to function with as much independence as possible, the following correction actions will be implemented:** 1) To ensure that the clients are encouraged to practice independence during meal times, all staff located at the location of 2453 South 100 East (Bobtail group home) will be re-trained on family style dining. *Refer to Appendix K for Record of Training form to be used to document training*	07/18/2014

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	in the kitchen assisting staff to cook. Client #7 sat at the counter eating cereal, client #1 walked in and out of the kitchen looking at staff cook, client #3 sat outside smoking, clients #4 and #8 sat at the dining room table, client #5 stayed in his bedroom and client #6 was taking a shower. Although client #1 opened cans of fruit with a can opener, the client was not encouraged to participate in the cooking of the food. Clients #1 and #7 indicated they did not like lima beans. Facility staff #5 placed corn on the stove to cook. Facility staff did not encourage clients #1 and/or #7 to help prepare the corn/substitute item. Clients #1 and #2 helped set the dining room table for dinner and client #7 carried the milk to the table without assistance/training. Staff carried the pork chops, potatoes, fruit mix and corn to the table without encouraging clients #1, #2, #3, #4, #5, #6. #7 and/or #8 to participate. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 6/9/14 at 3:00 PM indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 should be involved in all aspects of the meal preparation. 9-3-8(a)			

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