

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G744	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/12/2016
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2453 S 100 E PERU, IN 46970
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W 0000  Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>This visit was in conjunction with the post-certification revisit survey (PCR) to the investigation of complaint #IN00185316 completed on 2/15/16.</p> <p>Dates of Survey: 4/5, 4/6, 4/7 and 4/12/16.</p> <p>Facility Number: 006630 Provider Number: 15G744 AIM Number: 200902110</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/18/16.</p>	W 0000		
W 0130  Bldg. 00	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview for 1 of 4 sampled clients (Client #1) and 1 additional client (#8) the facility failed to protect client #1's and #8's privacy while toileting.</p>	W 0130	<p><b>W130</b> <b>Finding(s):</b> <b>1. "Based on interview and record review for 1 of 4 sampled clients (client #1) and 1 additional client (#8) the facility failed to protect client</b></p>	05/12/2016

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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W 0153  Bldg. 00	<p>Findings include:</p> <p>During the 4/5/16 observation period between 4:00pm and 6:15pm client #1 stood in the back bathroom clapping his hands. At 4:36pm client #8 came running down the hall way stating "I've got to use the restroom." When client #8 went to the bathroom she stated "Oh hi [client #1]" and shut the door behind her. Client #8 used the restroom while client #1 remained in the restroom with her.</p> <p>At 4:59pm client #1 was back in the bathroom. He was sitting on the toilet naked with the bathroom door open while using the restroom.</p> <p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked if client #8 should use the restroom while other clients are in the restroom, the AD stated "No." When asked if client #1 should use the restroom with the door open, the AD stated "No."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations</p>		<p><b>#1 and client #8's privacy while toileting."</b></p> <p><b>Corrective Action(s):</b></p> <p><b>To ensure that client #1 and client #8's privacy is protected while toileting:</b></p> <p>1. The Qualified Intellectual Disabilities Professional will implement informal program goals for teaching opportunities to teach client #1 and #8 to shut the bathroom door when in the bathroom. All staff located in the home will be trained on the informal goals. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>All staff located in the home will be retrained on Protection of Client Rights. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight</p>		

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	<p>of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review for 1 of 4 investigations of injuries of unknown source reviewed, the facility failed to immediately report injuries of unknown source to the administrator for client #8.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/5/16 at 1:37pm. The 3/15/16 reportable incident report indicated "[Client #8] has a bruise on her right bottom cheek that is 2 1/2 inches in a circular shape. It is believed that this bruise occurred from the day before when she was having a behavior and fell." The reportable incident report indicated the bruise was found on 2/19/16 but not reported to state officials until 3/15/16.</p> <p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked when injuries of unknown source should be reported to the administrator, the AD stated "When it is</p>	W 0153	<p><b>W153</b></p> <p><b>Finding(s):</b></p> <p><b>1. "Based on observation, record review, and interview for 1 of 4 investigations of injuries of unknown source the facility failed to immediately report injuries of unknown source to the administrator for client #8."</b></p> <p><b>Corrective Action(s):</b></p> <p><b>To ensure that all injuries of unknown source are reported to administration immediately:</b></p> <p>1. All staff located in the home will be retrained on reportable incidents, accident/injury reports and the policy and procedure for reporting those immediately to administration. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>2. All accident/injury reports are signed by the Residential Director and The Executive Vice President for review to ensure that all reportable incidents have been reported and investigated. Any accident/injury that has not been reported immediately will</p>	05/12/2016

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W 0156 Bldg. 00	<p>discovered."</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on interview and record review for 1 of 4 investigations of injuries of unknown source reviewed, the facility failed to complete investigations within 5 working days for client #6.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/5/16 at 1:37pm. The 3/17/16 reportable incident report indicated "While staff was assisting [client #6] in changing his brief she noticed a 1 inch by 1 1/2 inch bruise on his upper left thigh. Earlier in the morning [client #6] had slid out of his wheelchair to crawl/move to another part of the room. As he slid out of his wheelchair he hit his upper left thigh on the foot rest. It is believed that the bruise is from when he slid out of his</p>	W 0156	<p>result in staff retraining and disciplinary measures. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p><b>W156</b> <b>Finding(s):</b> <b>1. "Based on interview and record review for 1 of 4 investigations of injuries of unknown source reviewed, the facility failed to complete investigations within 5 working days for client #6."</b></p> <p><b>Corrective Action(s):</b> <b>To ensure that all investigations of injuries of unknown source are completed within 5 working days.</b> 1. The Social Service Coordinator will be retrained on Bona Vista's policy and procedures for conducting investigations and the State law of completion of investigations of Unknown source of injuries. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for</p>	05/12/2016

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W 0225 Bldg. 00	<p>wheelchair to crawl/move to another part of the room hitting his left upper thigh on the foot rest. To ensure the initiate (sic) finding are (sic) that the bruise came from [client #6] sliding out of his chair an investigation of unknown origins will be opened." The Residential Services Investigation Checklist indicated the investigation was opened on 3/18/16 and the investigation was closed on 4/1/16.</p> <p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked why the investigation for the 3/17/16 injuries of unknown source took more than 5 working days, the AD stated "There is no good explanation".</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review and interview for 1 additional client (#6) the facility failed to complete a vocational assessment for client #6.</p> <p>Findings include:</p>	W 0225	<p>administrative oversight. 2.The Social Service Coordinator, TheAssistant Director, and The Residential Director will meet weekly to discussall investigations and completion dates to give administrative oversight andmonitoring to the investigations.</p> <p><b>W225</b> <b>Finding(s):</b> <b>1. "Based on observation, interview and record review for 1 additional client (#6) the facility failed to complete a vocational assessment."</b> <b>CorrectiveAction(s):</b></p>	05/12/2016			

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	<p>During the 4/6/16 observation period between 12:59pm and 2:48pm client #6 was the only client home for day services. At 12:59pm client #6 was prompted by staff #1 to get into his wheelchair to change his clothes. At 1:07pm staff #1 returned with client #6 and assisted him back into his recliner. At 1:22pm staff #1 fixed client #6 a drink in the kitchen and brought it to him in the living room. At 1:25pm staff #1 took client #6 back to the med room for his medication pass. At 1:30pm client #6 was brought back into the living room and assisted back into the recliner. At 1:43pm staff #1 told client #6 that she needed to go check his clothes. Staff #1 brought client #6's clothes back out into the kitchen and put them on the island in the kitchen. Staff #1 folded and put away client #6's clothes while he remained in the recliner. At 1:53pm staff #1 assisted client #6 into his wheelchair to take him back and change him again. At 2:02pm staff #1 returned with client #6 and assisted him back into the recliner. At 2:13pm client #6 was prompted by staff #1 to sit properly in his seat. At 2:29pm staff #5 arrived at the home and refilled client #6's cup for him. At 2:48pm client #6 was assisted into the kitchen and had a snack. Client #6 was not prompted to participate in any objectives.</p>		<p><b>Toensure that client #6 receives a vocational assessment and a day time activetreatment schedule is followed.</b></p> <p>1. Client#6 will receive a vocational assessment from the day service provider. Therewill be a daytime active treatment schedule made for client #6 to follow.</p> <p>2. Client#6 will be attending the Community Connections facility in Kokomo, Indianastarting out 2 days a week for his day services. It will be assessed after amonth to decide if his days will increase to three times a week. All stafflocated in the group home and the Community Connections day services will betrainon Client #6's plans and daytime active treatment schedule. Record ofTraining forms will be completed following staff trainings and will besubmitted to the Residential Director for administrative oversight.</p>	

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	<p>Client #6's record was reviewed on 4/7/16 at 12:47pm. Client #6's 5/18/15 ISP (Individualized Support Plan) indicated client #6 had the following objectives (not all inclusive): "I will identify currency from various coins starting with a penny with 3 or less verbal prompts". "I will place the spoon in my mouth with medications with 3 or less verbal prompts". "I will prepare my drink with three or less verbal prompts". "I will sit on the toilet with 5 or less verbal prompts". "I will use the sign for drink with one or less verbal prompt". "I will display appropriate ways to gain attention with five or less verbal prompts". "I will identify the hot water faucet when prompted with three or less verbal prompts". "I will display appropriate community interaction with five or less verbal prompts".</p> <p>Client #6's 5/18/15 Person Centered Description indicated client #6 "isn't currently employed, but attends community connections through [name of provider]". Client #6's ISP or person Centered Description did not indicate client #6's work interests, work skills, work attitudes, work behavior and/or present and future work options were assessed.</p>			

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W 0227 Bldg. 00	<p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked if client #6 had a vocational assessment completed, the AD stated "No".</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview for 1 of 4 sampled clients (#1) the facility failed to address client #1's blindness when it comes to dining independently.</p> <p>Findings include:</p> <p>During the 4/5/16 observation period between 4:00pm and 6:15pm clients sat down at the kitchen table to make their plates for dinner. At 6:15pm client #1's plate was placed in front of him. The HM (House Manager) did not communicate to client #1 what was on his plate or where his food was located on his plate. The HM tried to put the spoon in client #1's hand but he did not</p>	W 0227	<p><b>W227</b> <b>Finding(s):</b> 1. "Based on observation, interview and record review for 1 of 4 sampled clients (#1) the facility failed to address client #1's blindness when it comes to dining independently."</p> <p><b>Corrective Action(s):</b> To ensure client #1 has formal/informal goals and/or plans to be able to dine independently. 1. The Qualified Intellectual Disabilities Professional will incorporate formal/informal goals and/or dining plans so that client #1 can have independence with his dining. All staff in the home</p>	05/12/2016

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	<p>want it. The HM fed client #1 a bite of taco bake. He took one bite then pushed staff away. The HM indicated this was client #1 communicating he did not want that and replaced his plate of taco bake with a plate of chicken nuggets. The HM put client #1's hand on nuggets and he began to eat them.</p> <p>Client #1's record was reviewed on 4/6/16 at 11:58am. Client #1's 12/22/14 physical indicated client #1 had a diagnosis of blindness. Client #1's 9/29/15 vision plan indicated client #1's staff will "assist [client #1] with walking from place to place to insure his safety, prompt [client #1] to use his walking stick at all times, will document [client #1's] progress with his walking stick in their daily notes, and will make sure the areas that they are walking are free of obstacles or any hazards for [client #1]". Client #1's vision plan did not indicate how staff should assist client #1 while he was eating.</p> <p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked if client #1's blindness plan indicated how staff should assist client #1 with dining, the AD stated "No". When asked if client #1 had a</p>		<p>will be trained on any additions made to client #1's goals and plans. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>2. All informal/formal goals and/or plans will be submitted to the Residential Director for approval prior to any training done with the staff that are located in the home. The Residential House Manager and The Residential Lead DSP will ensure that client #1's goals and plans are being implemented and followed by the direct support professionals that work in the home.</p>	

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W 0249 Bldg. 00	<p>dining plan that indicated how staff should assist client #1 with dining, the AD stated "No".</p> <p>9-3-4(a)</p> <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, record review, and interview for 2 of 4 sampled clients (#1 and #2) and 1 additional client (#6) the facility to ensure the clients' vision programs and/or objectives were implemented when opportunities were present.</p> <p>Findings include:</p> <p>1. During the 4/5/16 observation period between 4:00pm and 6:15pm and the 4/6/16 observation period between 6:30am and 8:21am client #1 walked independently with no assistive devices.</p> <p>Client #1's record was reviewed on 4/6/16 at 11:58am. Client #1's 12/22/14 physical indicated client #1 had a diagnosis of blindness. Client #1's</p>	W 0249	<p><b>W249</b></p> <p><b>Finding(s):</b></p> <p><b>1. "Based on observation, interview, and record review for 2 of 4 sampled clients (#1 and #2) and 1 additional client (#6) the facility failed to ensure the clients' vision programs and/or objectives were implemented when opportunities were present."</b></p> <p><b>Corrective Action(s):</b></p> <p><b>1. To ensure that all clients' programs and/or objectives were implemented when opportunities were present and that active treatment was program was consistent of the needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the</b></p>	05/12/2016	

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	<p>9/29/15 vision plan indicated client #1's staff will "assist [client #1] with walking from place to place to insure his safety, prompt [client #1] to use his walking stick at all times, will document [client #1's] progress with his walking stick in their daily notes, and will make sure the areas that they are walking are free of obstacles or any hazards for [client #1]".</p> <p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked if client #1 should use his walking stick, the AD stated "He has it, but he doesn't like to use it".</p> <p>2. During the Medication pass on 4/6/16 at 6:50am client #2 was brought to the medication room. Before client #2 was brought to the medication room Staff #1 prepared his medications for him. Staff #1 spoon fed client #2 his medication without communicating to client #2.</p> <p>Client #2's record was reviewed on 4/6/16 at 1:35pm. Client #2's 2/8/16 ISP (Individualized Support Plan) indicated client #2 had the following formal objective "I will identify which pill is my clonazepam (yellow pill) and why I take it (seizures) with 3 or less verbal prompts".</p>		<p><b>Individual program plan."</b></p> <p>1.Allstaff located in the home will be retrained on all persons served formal andinformal programs and/or objectives and implementing these formal and informalprograms when opportunities are present. Record of Training forms will becompleted following staff trainings and will be submitted to the ResidentialDirector for administrative oversight.</p> <p>2.TheResidential House Manager and The Residential Lead DSP are in the group homeseven days a week and will monitor, supervise, and observe staff to ensure thatall formal and informal programs and/or objectives are being provided whenopportunities are present.</p> <p>3.Allformal and informal programming goals that are completed are documented in theclients' goal book. This goal book is monitored weekly by the Lead DirectSupport professional and the Residential house Manager. The ResidentialQualified Intellectual Disabilities Provider (QIDP) reviews all informal andformal program goal documentation monthly and puts the information in a monthlyreport that is handed in to the Residential Director for review.</p>		

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	<p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked when client #2 should participate in med training, the QIDP stated "He has a goal to be run at every med pass."</p> <p>3. During the 4/6/16 observation period between 12:59pm and 2:48pm client #6 was the only client home for day services. At 12:59pm client #6 was prompted by staff #1 to get into his wheelchair to change his clothes. At 1:07pm staff #1 returned with client #6 and assisted him back into his recliner. At 1:22pm staff #1 fixed client #6 a drink in the kitchen and brought it to him in the living room. At 1:25pm staff #1 took client #6 back to the med room for his medication pass. At 1:30pm client #6 was brought back into the living room and assisted back into the recliner. At 1:43pm staff #1 told client #6 that she needed to go check his clothes. Staff #1 brought client #6's clothes back out into the kitchen and put them on the island in the kitchen. Staff #1 folded and put away client #6's clothes while he remained in the recliner. At 1:53pm staff #1 assisted client #6 into his wheelchair to take him back and change him again. At 2:02pm staff #1 returned</p>			

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2453 S 100 E PERU, IN 46970
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	<p>with client #6 and assisted him back into the recliner. At 2:13pm client #6 was prompted by staff #1 to sit properly in his seat. At 2:29pm staff #5 arrived at the home and refilled client #6's cup for him. At 2:48pm client #6 was assisted into the kitchen and had a snack. Client #6 was not prompted to participate in any objectives.</p> <p>Client #6's record was reviewed on 4/7/16 at 12:47pm. Client #6's 5/18/15 ISP (Individualized Support Plan) indicated client #6 had the following objectives (not all inclusive): "I will identify currency from various coins starting with a penny with 3 or less verbal prompts". "I will place the spoon in my mouth with medications with 3 or less verbal prompts". "I will prepare my drink with three or less verbal prompts". "I will sit on the toilet with 5 or less verbal prompts". "I will use the sign for drink with one or less verbal prompt". "I will display appropriate ways to gain attention with five or less verbal prompts". "I will identify the hot water faucet when prompted with three or less verbal prompts". "I will display appropriate community interaction with five or less verbal prompts".</p> <p>An interview with the Area Director (AD), the House Manager (HM) and the</p>			

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W 0250 Bldg. 00	<p>QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked if client #6 had goals and objectives that he should have been working on during the day program observation, the AD stated "Yes".</p> <p>9-3-4(a)</p> <p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on observation, record review and interview for 1 additional client (#6) the facility failed to complete an active treatment schedule for client #6.</p> <p>Findings include:</p> <p>During the 4/6/16 observation period between 12:59pm and 2:48pm client #6 was the only client home for day services. At 12:59pm client #6 was prompted by staff #1 to get into his wheelchair to change his clothes. At 1:07pm staff #1 returned with client #6 and assisted him back into his recliner. At 1:22pm staff #1 fixed client #6 a drink in the kitchen and brought it to him in the living room. At 1:25pm staff #1 took client #6 back to the med room for his medication pass. At</p>	W 0250	<p><b>W250</b> <b>Finding(s):</b></p> <p><b>1. "Based on observation, interview and record review for 1 additional client (#6) the facility failed to develop and implement an active treatment schedule."</b></p> <p><b>Corrective Action(s):</b> <b>To ensure that client #6 receives an active treatment schedule that is implemented and followed.</b></p> <p>1. Client #6 will receive a vocational assessment from the day service provider. There will be a daytime active treatment schedule made for client #6 to follow. Client #6 will be attending the Community Connections facility in Kokomo, Indiana starting out</p>	05/12/2016

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	<p>1:30pm client #6 was brought back into the living room and assisted back into the recliner. At 1:43pm staff #1 told client #6 that she needed to go check his clothes. Staff #1 brought client #6's clothes back out into the kitchen and put them on the island in the kitchen. Staff #1 folded and put away client #6's clothes while he remained in the recliner. At 1:53pm staff #1 assisted client #6 into his wheelchair to take him back and change him again. At 2:02pm staff #1 returned with client #6 and assisted him back into the recliner. At 2:13pm client #6 was prompted by staff #1 to sit properly in his seat. At 2:29pm staff #5 arrived at the home and refilled client #6's cup for him. At 2:48pm client #6 was assisted into the kitchen and had a snack. Client #6 was not prompted to participate in any objectives.</p> <p>Client #6's record was reviewed on 4/7/16 at 12:47pm. Client #6's 5/18/15 ISP (Individualized Support Plan) indicated client #6 had the following objectives (not all inclusive): "I will identify currency from various coins starting with a penny with 3 or less verbal prompts". "I will place the spoon in my mouth with medications with 3 or less verbal prompts". "I will prepare my drink with three or less verbal prompts". "I will sit on the toilet with 5 or less</p>		<p>2days a week for his day services. It will be assessed after a month to decideif his days will increase to three times a week. All staff located in the grouphome and the Community Connections day services will be trained on Client #6's plans and daytime active treatment schedule. Record of Training forms will becompleted following staff trainings and will be submitted to the ResidentialDirector for administrative oversight</p>				

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W 0261 Bldg. 00	<p>verbal prompts". "I will use the sign for drink with one or less verbal prompt". "I will display appropriate ways to gain attention with five or less verbal prompts". "I will identify the hot water faucet when prompted with three or less verbal prompts". "I will display appropriate community interaction with five or less verbal prompts". Client #6's ISP did not indicate he had an active treatment schedule in place.</p> <p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked if client #6 had an active treatment schedule in place, the AD stated "No".</p> <p>9-3-4(a)</p> <p>483.440(f)(3) PROGRAM MONITORING &amp; 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 practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. Based on interview and record review for 4 of 4 sampled clients (#1, #2, #3, and</p>	W 0261	<b>W261 Finding(s):</b> <b>1. "Based on interview and</b>	05/12/2016			

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W 0263 Bldg. 00	<p>#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 were reviewed on 4/7/16 at 10:33am. 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 2/23/2016.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked when the last time a client member of the HRC attended and participated in a meeting, the RD stated "No we don't. We are working on it."</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client,</p>		<p><b>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 client participation in its Human Rights Committee (HRC) meetings."</b></p> <p><b>CorrectiveAction(s): Toensure client participation in all Human Rights Committee (HRC) meetings.</b></p> <p>1. The Qualified IntellectualDisabilities Professional will ensure that there is a client that participates in all Human Rights Committee (HRC) meetings.</p> <p>2. The Residential Director and TheAssistant Director will attend all HRC meetings and ensure that there is aclient participating in those meetings to show administrative oversight.</p>	

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	<p>parents (if the client is a minor) or legal guardian.</p> <p>Based on observation, record review and interview for 2 of 4 sampled clients (#2 and #4), the facility failed to obtain written informed consent from client #2's legal guardian for the use of bed alarms and from client #4 for an increase in behavior medication.</p> <p>Findings include:</p> <p>1. During the 4/5/16 observation period between 4:00pm and 6:15pm client #2 had a bed alarm attached to his bed.</p> <p>Client #2's record was reviewed on 4/6/16 at 1:35pm. Client #2's 2/8/16 ISP (Individualized Support Plan) indicated client #2's sister acted as his legal guardian. Client #2's record indicated client #2 received a prescription on 2/29/16 for the use of the bed alarms. Client #2's record did not indicate client #2's guardian gave written informed consent for the use of the bed alarms.</p> <p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked if client #2's guardian gave written informed consent for the use of the bed alarms, the QIDP stated "I know we got it, I'll find it". The</p>	W 0263	<p><b>W263</b> <b>Finding(s):</b></p> <p><b>1. "Based on interview and record review for 2 of 4 sampled clients (#2 and #4), the facility failed to obtain written informal consent from client #2's legal guardian for the use of bed alarms and from client #4's for an increase in behavior medication."</b></p> <p><b>Corrective Action(s):</b> <b>To ensure that written informal consent is obtained from the guardian of client #2's guardian for the use of bed alarms and client #4's guardian for an increase in behavior medication.</b></p> <p>1. The Qualified Intellectual Disabilities Professional (QIDP) will obtain written informed consent from client #2's guardian for the use of bed alarms. The QIDP will submit a copy of the written informed consent to the Residential Director to ensure completion and for administration oversight.</p> <p>2. The Qualified Intellectual Disabilities Professional (QIDP) will obtain written informed consent from client #4's guardian for the increase in behavior medication. The QIDP will submit a copy of the written informed consent to the Residential Director to ensure completion and for administration</p>	05/12/2016

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W 0322  Bldg. 00	<p>facility was unable to provide written informed consent for review.</p> <p>2. Client #4's record was reviewed on 4/7/16 at 10:34am. Client #4's March 2016 BSP (Behavior Support Plan) indicated client #4 was his own guardian. Client #4's BSP indicated he took Depakote, Clonazepam, Risperidone, and Prozac for behaviors.</p> <p>Client #4's 12/2/15 Counselors note indicated client #4 had increased agitation and aggression and his Prozac was increased. Client #4's record did not indicate client #4 gave written informed consent for the medication increase.</p> <p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked if client #4 gave written informed consent for the increase in his Prozac, the AD stated "No, not written down anywhere".</p> <p>9-3-4(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.</p>		<p>oversight.</p> <p>3. The Assistant Residential Director will do a Periodic Service Review on a quarterly basis. The Assistant Director will ensure clients' that have guardians will have obtained written informed consent when required. All Periodic Service Reviews will be turned into the Residential Director for additional oversight and administrative monitoring.</p>		

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W 0331  Bldg. 00	<p>Based on interview and record review, for 2 of 4 sampled clients (clients #1 and #2), the facility failed to complete clients' annual physicals.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 4/6/16 at 11:58am. Client #1's record indicated client #1's last annual physical was completed on 12/22/14.</p> <p>Client #2's record was reviewed on 4/6/16 at 1:35pm. Client #2's record indicated client #2's last annual physical was completed on 3/26/15.</p> <p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked if client #1 or #2 had recent annual physicals, the AD stated "I'll have to look". The facility was unable to provide annual physicals for clients #1 and #2 for review.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and</p>			W 0322	<p>W322 Findings "Based on interview and record review, for 2 of 4 sampled clients (Clients #1 and #2), the facility failed to complete annual physicals" Corrective Actions: To ensure that clients' #1 and #2 obtain annual physicals 1) Client #1 and #2 will receive annual physicals by there doctors All clients will receive annual physicals by their doctors and the physical will be kept in their consumer binder The Residential Nurse responsible for the missed physicals is no longer an employee with Bona Vista Any additional nurses will be trained on the annual physicals in their introductory training 2) The Assistant Director does a periodic service review quarterly and will ensure that annual physicals are completed when it is warranted to ensure additional administrative oversight and monitoring</p>		05/12/2016
				W 0331	<b>W331</b>		05/12/2016

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	<p>interview for 1 of 4 sampled clients (#2) the facility's nursing staff failed to update client #2's seizure management plan to include the use of the bed alarms.</p> <p>Findings include:</p> <p>During the 4/5/16 observation period between 4:00pm and 6:15pm client #2 had a bed alarm attached to his bed.</p> <p>Client #2's record was reviewed on 4/6/16 at 1:35pm. Client #2's record indicated client #2 received a prescription on 2/29/16 for the use of the bed alarms. Client #2's record did not indicate client #2's 3/10/16 seizure management plan included the use of the bed alarms.</p> <p>An interview with the Area Director (AD), the House Manager (HM), QIDP (Qualified Intellectual Disabilities Professional), and the Nurse was conducted on 4/7/16 at 2:21pm. When asked if client #2's seizure management plan was updated to include the use of the bed alarms, the nurse stated "No".</p> <p>9-3-6(a)</p>		<p><b>Finding(s):</b></p> <p><b>1. "Based on observation, interview and record review for 1 of 4 sampled clients' (#2) the facility's nursing staff failed to update client #2's seizure management plan to include the use of the bed alarms."</b></p> <p><b>Corrective Action(s):</b> <b>To ensure that client #2's seizure management plan is updated including the bed alarms.</b></p> <p>1. The Residential Nurse will update client #2's seizure management plan to include the bed alarms.</p> <p>2. All staff located in the home will be trained on the revised seizure management plan. 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 Assistant Residential Director will do a Periodic Service Review on a quarterly basis. The Assistant Director will ensure plans have been updated and revised according to their needs and doctor orders and recommendations. All Periodic Service Reviews will be turned into the Residential Director for additional oversight and administrative monitoring.</p>				

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W 0382  Bldg. 00	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 1 additional client (#6) the facility failed to keep controlled substances locked when not administering.</p> <p>Findings include:</p> <p>During the 4/6/16 observation period between 6:30am and 8:21am Staff #2 passed client #6's medications. At 7:00am staff #2 took the controlled substance lock box out of another locked cabinet and set it on the desk. Staff #2 popped client #2's medications into the a cup and waited for him to be brought to the medication room. HM (House Manager) brought client #6 to the medication room and suggested client #6 be taken to the bathroom so they could shut the door. Staff #2 and the HM left the medication room with client #6 and went into the bathroom. Staff #6 left the controlled substance box unlocked on the desk and the door to the medication room unlocked when she left. At 7:02am staff #2 returned to the medication room.</p> <p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities</p>	W 0382	<p><b>W382</b> <b>Finding(s):</b></p> <p><b>1. "Based on observation and interview for 1 additional client (#6) the facility failed to keep controlled substances locked when not administering."</b></p> <p><b>Corrective Action(s):</b> <b>To ensure that controlled substances are locked up when not administering.</b></p> <p>1. All staff located in the home will be retrained on the controlled substance policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>2. The Residential House Manager and Residential Lead Direct Support Professional are in the home 7 days a week and will monitor and observe that all controlled substances are being locked when not being administered for additional monitoring and oversight.</p>	05/12/2016			

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W 0436 Bldg. 00	<p>Professional) was conducted on 4/7/16 at 2:21pm. When asked if the controlled substance box should be left unattended by staff the AD stated "No".</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>Based on observation, record review, and interview for 2 of 4 sampled clients with adaptive equipment (#1 and #4) the facility failed to encourage clients #1 and #4 to use their adaptive equipment.</p> <p>Findings include:</p> <p>During the 4/5/16 observation period between 4:00pm and 6:15pm and the 4/6/16 observation period between 6:30am and 8:21am client #4 did not wear eye glasses. Staff did not prompt client #4 to wear his eye glasses at anytime.</p> <p>Client #4's record was reviewed on 4/7/16 at 10:34am. Client #4's 2/9/16 risk management assessment and plan</p>	W 0436	<p><b>W436</b> <b>Finding(s):</b></p> <p><b>1. "Based on observation, record review, and interview for 2 of 4 sampled clients with adaptive equipment (#1 and #4) the facility failed to encourage clients #1 and #4 to use their adaptive equipment."</b></p> <p><b>Corrective Action(s):</b> <b>To ensure that client #1 and #4 use all doctor ordered adaptive equipment when required.</b></p> <p>1. All staff located in the home will be retrained on client #1 and #4's doctor ordered adaptive equipment and the use of the adaptive equipment. Record of</p>	05/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G744	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/12/2016
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2453 S 100 E PERU, IN 46970
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	<p>indicated client #4 wears prescription glasses. Client #4's 11/13/15 eye exam indicated client #4 had "new glasses prescribed/bifocals".</p> <p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked when client #4 should wear his eye glasses, the AD stated " He should wear them at all times".</p> <p>During the 4/5/16 observation period between 4:00pm and 6:15pm and the 4/6/16 observation period between 6:30am and 8:21am client #1 walked independently with no assisted devices.</p> <p>Client #1's record was reviewed on 4/6/16 at 11:58am. Client #1's 12/22/14 physical indicated client #1 had a diagnosis of blindness. Client #1's 9/29/15 vision plan indicated client #1's staff will "assist [client #1] with walking from place to place to insure his safety, prompt [client #1] to use his walking stick at all times, will document [client #1's] progress with his walking stick in their daily notes, and will make sure the areas that they are walking are free of obstacles or any hazards for [client #1]".</p>		<p>Training forms will be completed following staff trainings and will besubmitted to the Residential Director for administrative oversight.</p> <p>2.TheResidential House Manager and Residential Lead Direct Support Professional arein the home 7 days a week and will monitor and observe that all adaptiveequipment is being used as per doctor orders for client #1 and #4 foradditional monitoring and oversight.</p>	

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W 0454 Bldg. 00	<p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked if client #1 should use his walking stick, the AD stated "He has it, but he doesn't like to use it".</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation and interview for 1 of 4 sampled clients (Client #3) the facility failed to prevent the spread of germs between clients.</p> <p>Findings include:</p> <p>During the 4/5/16 observation period between 4:00pm and 6:15pm clients sat down at the kitchen table to make their plates for dinner. At 5:56pm client #3 was putting sour cream on her taco bake. Client #3 put the sour cream on her meal then put the spoon in her mouth cleaning the remainder of the sour cream off her spoon. Client #3 put the spoon back in the sour cream and put more sour cream on her plate. Client #3 put the spoon</p>	W 0454	<p><b>W454</b> <b>Finding(s):</b></p> <p><b>1. "Based on observation and interview for 1 of 4 sampled clients (client #3) the facility failed to prevent the spread of germs between clients."</b></p> <p><b>Corrective Action(s):</b> <b>To ensure the spread of germs between clients.</b></p> <p>1. All staff located in the home will be retrained on family style dining and handwashing. Record of Training forms 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 will</p>	05/12/2016

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	<p>back into her mouth then back into the sour cream. Client #4 and #6's plates were made using the spoon client #3 put in her mouth.</p> <p>An interview with the Area Director (AD), the House Manager (HM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 4/7/16 at 2:21pm. When asked if clients should serve themselves with a spoon once another client put the spoon in their mouth, the AD stated "No".</p> <p>9-3-7(a)</p>		<p>implement an informal program goal for client #3 for not spreading germs and appropriate use of dining utensils during group dining. All staff located in the home will be trained on the new goals. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p>		