

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/17/2014
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: January 8, 9, 10, 13, 14, 15, 16, and 17, 2014.</p> <p>Facility Number: 0012485 Provider Number: 15G789 AIMS Number: 201012970</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed January 27, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 4 additional clients (clients #5, #6, #7, and #8) who lived in the group home, the governing body failed to exercise operating direction over the facility to complete maintenance and repairs at the group</p>	W000104	The ongoing maintenance of the physical structure does have a monitoring system in place. The repair items cited by the surveyor were already identified and the gathering of estimates and scheduling of work had already begun. The physical structures are reviewed weekly and monthly in the following manner: 1. Residential house	02/16/2014

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

TITLE

(X6) DATE

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

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	<p>home for the worn finish on the dining room table, for 4 of 4 bathroom showers stained a golden brown, and the worn finish on the living room and dining room wooden floors.</p> <p>Findings include:</p> <p>On 1/10/14 from 6:20am until 8:12am, and on 1/13/14 from 2:45pm until 5:45pm, observations were conducted at the group home. During both observation periods, clients #1, #2, #3, #4, #5, #6, #7, and #8 walked and/or moved themselves throughout the group home. During both observation periods, the dining room table had a worn finish which exposed the wood at each of the eight table placements where a chair was positioned. On 1/13/14 from 2:45pm until 5:45pm, client #2 sat, lay, and crawled on the living room hardwood floor with a worn finish. During both observation periods, clients #1, #3, #4, #5, #6, #7, and #8 used the four stained a golden brown bathroom showers to bathe. On 1/13/14 at 2:45pm, an interview with the Residential Manager (RM) was conducted during observation. The RM indicated the dining room table's wooden finish was worn and exposed the bare wood. The RM indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 used</p>		<p>manager completes a weekly safety report that is for the express purpose of reporting maintenance issues. The form was updated to include a section to report carpet stains and paint needs (Appendix A). This is sent to the Vice President of Residential Services, the Senior Vice President, and the Coordinator of Maintenance. 2. The Vice President of Residential Services completes a monthly environmental checklist. (Appendix B). 3. The maintenance department completes a preventative maintenance checklist (Appendix C). All of these checks are in place to identify needed maintenance issues. Maintenance staff will be completing the repair on the finish of the dining room table by February 16, 2014. The replacement of the shower units has begun and will be completed by February 16, 2014. The worn spots on the floor will be repaired by February 16, 2014.</p>				

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	<p>the dining room table to eat and for activity daily. The RM indicated four of four (4 of 4) bathroom showers had a golden brown color "lime build up" inside each shower which covered three of three walls in each of the showers. The RM indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 used the showers to bathe daily. When asked what color the showers should have been. The RM stated "White." The RM indicated the living room and dining room hardwood floors' finish was worn and needed repair.</p> <p>On 1/15/14 at 3:00pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional), the Residential Manager (RM), and the DGHL (Director of Group Home Living) was conducted. The QIDP, the RM, and the DGHL indicated the group home maintenance requests had been submitted for the dining room table and the dining room/living room wooden floors. On 1/15/14 at 3:00pm, the DGHL provided the 2014 "Work Requested" sheet of paper and the DGHL stated the work requested did not include the dining room table, the dining room/living room hardwood floor finish, and/or the bathroom showers with the golden brown "lime build up." The RM indicated clients #1, #2, #3, #4, #5, #6,</p>			

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W000130	<p>#7, and #8 lived in the group home. The RM indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 sat at and ate meals on the dining room table with the worn wooden finish.</p> <p>9-3-1(a)</p> <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. Based on observation, record review, and interview, for 1 of 4 sampled clients (clients #1) and 3 additional clients (clients #5, #6, and #8), the facility failed to encourage and teach personal privacy when opportunities existed.</p> <p>Findings include:</p> <p>On 1/10/14 from 6:20am until 8:12am, and on 1/13/14 from 2:45pm until 5:45pm, observations were conducted at the group home. On 1/10/14 from 6:20am until 6:25am, client #1 in her nightgown without wearing a bathrobe, walked up/down the hallway. At 6:25am, client #1 (a female) entered a male peers' bedroom wearing her nightgown without a bathrobe; her nightgown outlined the impressions of</p>	W000130	<p>Personal privacy program goals were completed for client's 1, 5, 6, 8 (Appendix D, E, F, G). TheISP's for client's 1, 5, 6, 8 were also updated to reflect new program goals(Appendix H, I, J, K). All goals will be used to teach consumers the importance of respecting his/her own privacy aswell as the privacy of others. All staffwill be trained on updated program goals on 2/16/14. Additionally, staff will be retrained on client rights whichincludes the right to privacy (Appendix L). To ensure continued monitoring of compliance, residentialhouse managers review program goal documentation on a daily basis (Appendix M) toensure that staff are implementing goals. This documentation is turned in weekly to Vice President for ResidentialServices for review.</p>	02/16/2014	

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	<p>client #1's body shape. Client #1 entered male clients #3 and #7's shared bedroom, walked through the bedroom, and into client #3 and #7's connecting bathroom. Group Home Staff (GHS) #1, GHS #5, and GHS #7 walked into and out of client #3 and #7's shared bedroom without redirection to client #1. Client #1 showered and bathed in client #3 and #7's bathroom. When client #1 walked through the bedroom, both clients #3 and #7 watched from their individual beds. No redirection from the facility staff was observed. At 6:30am, client #8 exited his bedroom wearing only his briefs and no bathrobe, walked to the hallway bathroom, and went inside. A short time later client #8 exited the bathroom, wearing only his briefs, walked down the hallway, then walked back to his bedroom and was not redirected for personal privacy by GHS #1, GHS #5, or GHS #7 who passed client #8 in the hallway.</p> <p>On 1/10/14 from 6:20am until 6:45am, clients #5 and #6 were nude inside their bedroom with the door to the hallway open with GHS #5 and GHS #7 prompting and assisting both clients with dressing without redirection to shut the door. Both clients were in full view of the hallway and client #1 walked by the doorway.</p>						

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W000149	<p>On 1/17/14 at 2:35am, an interview was conducted with the Director of Group Home Living (DGHL) and the QIDP (Qualified Intellectual Disabilities Professional). Both staff indicated clients #1, #5, #6, and #8 did not have a personal privacy goal/objective in place to teach them personal privacy. Both staff indicated clients #1, #5, #6, and #8 should have been redirected during formal and informal opportunities to teach and encourage personal privacy during dressing and/or the clients' morning routines.</p> <p>Client #1's record was reviewed on 1/15/14 at 10:40am. Client #1's 4/4/13 ISP (Individual Support Plan) did not indicate a personal privacy goal/objective.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 2 of 2 BDDS (Bureau of Developmental Disabilities Services) reports (clients #1 and #7) reviewed of allegations of staff abuse, neglect, and/or mistreatment, the facility neglected to</p>	W000149	Bona Vista has a policy on the prevention of abuse, neglect, and mistreatment (Appendix N). All staff will be retrained on this policy. Further, staff will be retrained on BDDS reporting guidelines including immediately	02/16/2014			

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	<p>implement the facility's policy and procedure to prohibit staff abuse, neglect, and/or mistreatment, neglected to report allegations of abuse immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law, neglected to immediately investigate allegations, neglected to protect the clients from the potential of further staff abuse, and neglected to implement sufficient corrective action to retrain the staff on immediately reporting allegations and client supervision needs for clients #1 and #7.</p> <p>Findings include:</p> <p>1. On 1/10/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 01/1/13 through 01/10/14. The review indicated the following for client #1.</p> <p>-A 11/12/13 BDDS report for an incident reported on 11/11/13 for an incident on 11/9/13 at 6pm. The BDDS report indicated during a group outing in the community "an employee from a different [agency name] program happened to be at the same [store] and noticed [client #1] by herself and crying. Staff member approached [client #1]</p>		<p>reporting any instance of ANE immediately to management (Appendix O). BonaVista has a progressive disciplinary policy (Appendix P) for staff who fail to report immediately, and staff will be retrained on this policy on 2/16/14. For continued monitoring, the policy on ANE, immediate reporting, and prohibition of violation of rights was added to the annual compliance tracking (Appendix Q) and every staff will receive training two times per year on these topics. Staff will be retrained on the supervision needs for client's #1, 7 on February 16, 2014. To ensure that investigations are implemented immediately, QDDP, residential house manager, and residential nurse will be retrained on the agency policy on investigations (Appendix R) which includes immediately suspending the staff in question in order to protect the consumer. To ensure that all investigations are thorough and complete, the investigation documentation process has been revised to include the following elements: an interview form (Appendix S) that includes name of interviewee, name of interviewer, date of interview, and signature line. To ensure sufficient corrective action following an incident, the investigation documentation was revised to require the investigator to include a more detailed</p>				

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	<p>and asked her what was wrong and [client #1] told that staff member that she could not find her staff and was lost. The employee then had the staff paged that [client #1] said was with her and the other consumers during this outing." The report indicated GHS (Group Home Staff) #10 was suspended pending an investigation and "all" staff in the home will be retrained on the importance of providing a safe and secure environment for the consumers as well as responding appropriately to the needs of those consumers.</p> <p>-The 11/11/13 investigation indicated clients #1, #2, #3, #6, #7, and #8 went with GHS #2, GHS #4, and GHS #10 to an outside mall area shopping. The investigation indicated "staff reported that [GHS #10] did not supervise [client #1] during a group outing." The investigation indicated "Upon completion of investigation of neglect, writer feels that neglect can be substantiated in this case for all staff members present during the group outing on 11/9/13. The consumer, [client #1], has a history of elopement and has a BSP (Behavior Support Plan) that addresses elopement as well as should remain within the line of sight of all staff. During review with consumer [client #8] he stated that [client #1] was</p>		<p>summary of events (leading up to the incident, during the incident, after the incident) section (Appendix T). The revised documentation also requires the investigator to specify recommendations including actions to prevent recurrence (Appendix T), corrective action (action taken besides staff discipline as a response to the incident) (Appendix T). The QDDP, house manager, and lead staff supervisor will be trained 2/16/14. To ensure monitoring of this process, the QDDP will be required to report to Vice President of Residential Services, a summary of IDT meeting following a report of ANE. Further, the Lead Staff Supervisor, who has the primary responsibility for conducting investigations, will submit investigation material to VP for review to ensure all elements are included.</p>	

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	<p>in [GHS #10's] group with him (client #8) and furthermore [client #8] stated that [GHS #10] was aware of [client #1] wondering (sic) off and continued to walk on. Writer interviewed consumer [client #1] and she stated that she was in [GHS #10's] group and that she wandered off and got lost. Therefore, the allegation of neglect can be substantiated." The investigation did not document recommendations for corrective action for the substantiated neglect, did not indicate sufficient corrective action for retraining on client #1's supervision needs, did not indicate staff retraining on reporting the allegation immediately to the administrator and/or to BDDS in accordance with State Law.</p> <p>On 1/17/14 at 2:35pm, an interview with the Director of Group Home Living (DGHL) was conducted. The DGHL stated "It was substantiated neglect" when client #1 was not supervised in the community by the staff who were responsible for her. The DGHL indicated staff did not immediately report the allegation until 11/11/13. The DGHL indicated the facility staff did not protect client #1 from further neglect when they failed to immediately report the incident. The DGHL indicated the facility staff did not follow the facility's</p>				

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	<p>policy/procedure to prevent abuse/neglect/ and/or mistreatment. The DGHL indicated when she became aware of the incident she took immediate action. The DGHL indicated GHS #10 continued to work at the group home between 11/9/13 until 11/11/13. The DGHL stated client #1 did not possess community safety skills and was to have been within eyesight by the staff "at all times" while in the community. The DGHL indicated the investigation substantiated neglect by staff but no corrective action which included staff retraining for immediate reporting allegations/incidents and client #1's supervision needs in the community had been done.</p> <p>2. On 1/10/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 01/1/13 through 01/10/14. The review indicated the following for client #7.</p> <p>-A 5/25/13 BDDS report for an incident on 5/25/13 at 12:10am, indicated at 12:20am (on 5/25/13) GHS (Group Home Staff) #5 notified RHM [RHM #6] (Residential Home Manager) that client #7 "had fallen asleep on the couch in the living room. [GHS #5] said that [GHS #5] had verbally prompted [client #7] to wake up and go to his bed for at</p>						

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	<p>least an hour. At this time, co working staff [GHS #11] came into the living room, grabbed [client #7] by his shirt and pulled [client #7] up. [GHS #5] reported that [GHS #11] was pulling really hard to get [client #7] to get up, like it was almost choking [client #7]. [GHS #5] reported there was a red mark on [client #7's] shoulder." The report indicated "a full investigation has been started" and GHS #11 was suspended pending the outcome of the investigation. The agency RN (Registered Nurse) indicated a reddened area on client #7's neckline approximately two inches (2") long and a reddened area on client #7's right shoulder approximately one inch (1") in diameter.</p> <p>-A 5/31/13 Follow Up BDDS report to the 5/25/13 allegation indicated "Allegation of Physical Abuse was substantiated. Staff accused of physical abuse has been terminated" from employment.</p> <p>On 1/17/14 at 2:35pm, an interview with the Director of Group Home Living (DGHL) was conducted. The DGHL stated staff was suspended "after she became aware of the incident after 1pm" on 5/25/13. The DGHL indicated on 5/25/13 GHS #11 continued to work and</p>						

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	<p>finished her shift of work at the group home with client #7 and clients #1, #2, #3, #4, #5, #6, and #8 present at the group home. The DGHL indicated the facility staff the allegation was reported to was the residential manager. The DGHL indicated the residential manager did not report it to the office or take proactive measures to protect client #7 at 12:20am on 5/25/13 when made aware of the incident. The DGHL stated "No, [GHS #11] was not immediately suspended." The DGHL indicated no written investigation into client #7's incident on 5/25/13 was available for review. The DGHL stated the BDDS report was "our investigation until we attended the State of Indiana Abuse, Neglect, and Mistreatment Investigative Training provided within the past three months or so." The DGHL indicated no documented corrective action was available for review of: immediately reporting allegations of abuse, neglect, and/or mistreatment, protecting the clients from the potential of further abuse, completing a thorough investigation, documenting client witness statements, documenting staff witness statements, and/or documenting the results and recommendations of the investigation. The DGHL indicated the facility staff did not implement the facility's policy and procedure to protect</p>			

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	<p>client #7 from substantiated staff abuse.</p> <p>On 1/8/14 at 1:30 PM, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The guidelines indicated incidents should be immediately reported to the administrator and BDDS in accordance with state law, incidents should be thoroughly investigated, and sufficient corrective action taken.</p> <p>9-3-2(a)</p>				

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W000153	<p>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 immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, for 2 of 49 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (for clients #1 and #7), the facility failed to immediately report allegations of staff abuse and/or neglect to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>1. On 1/10/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 01/1/13 through 01/10/14. The review indicated the following for client #1.</p> <p>-A 11/12/13 BDDS report for an incident reported on 11/11/13 for an incident on 11/9/13 at 6pm. The BDDS report indicated during a group outing in the community "an employee from a different [agency name] program happened to be at the same [store] and noticed [client #1] by herself and crying. Staff member approached [client #1]</p>	W000153	Bona Vista has a policy on the prevention of abuse, neglect, and mistreatment (Appendix N). All staff will be retrained on this policy. Further, staff will be retrained on BDDS reporting guidelines including immediately reporting any instance of ANE immediately to management (Appendix O). Bona Vista has a progressive disciplinary policy (Appendix P) for staff who fail to report immediately, and staff will be retrained on this policy on 2/16/14. For continued monitoring, the policy on ANE, immediate reporting, and prohibition of violation of rights was added to the annual compliance tracking (Appendix Q) and every staff will receive training two times per year on these topics. Staff will be retrained on the supervision needs for client's #1, 7 on February 16, 2014. To ensure that investigations are implemented immediately, QDDP, residential house manager, and residential nurse will be retrained on the agency policy on investigations (Appendix R) which includes immediately suspending the staff in question in	02/16/2014			

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	<p>and asked her what was wrong and [client #1] told that staff member that she could not find her staff and was lost. The employee then had the staff paged that [client #1] said was with her and the other consumers during this outing." The report indicated GHS (Group Home Staff) #10 was suspended pending an investigation.</p> <p>On 1/17/14 at 2:35pm, an interview with the Director of Group Home Living (DGHL) was conducted. The DGHL stated "It was substantiated neglect" when client #1 was not supervised in the community by the staff who were responsible for her. The DGHL indicated staff did not report the 11/9/13 allegation until 11/11/13. The DGHL indicated the facility staff did not protect client #1 from further neglect when they failed to immediately report the incident. The DGHL indicated the facility staff did not follow the facility's policy/procedure to prevent abuse/neglect/ and/or mistreatment. The DGHL indicated when she became aware of the incident she took immediate action. The DGHL indicated GHS #10 continued to work at the group home between 11/9/13 until 11/11/13. The DGHL stated client #1 did not possess community safety skills and was to have been within eyesight by the staff</p>		<p>order to protect the consumer. To ensure that all investigations are thorough and complete, the investigation documentation process has been revised to include the following elements: an interview form (Appendix S) that includes name of interviewee, name of interviewer, date of interview, and signature line. To ensure sufficient corrective action following an incident, the investigation documentation was revised to require the investigator to include a more detailed summary of events (leading up to the incident, during the incident, after the incident) section (Appendix T). The revised documentation also requires the investigator to specify recommendations including actions to prevent recurrence (Appendix T), corrective action (action taken besides staff discipline as a response to the incident) (Appendix T). The QDDP, house manager, and lead staff supervisor will be trained 2/16/14. To ensure monitoring of this process, the QDDP will be required to report to Vice President of Residential Services, a summary of IDT meeting following a report of ANE. Further, the Lead Staff Supervisor, who has the primary responsibility for conducting investigations, will submit investigation material to VP for review to ensure all elements are included.</p>		

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	<p>"at all times" while in the community. The DGHL indicated the investigation substantiated neglect by staff.</p> <p>2. On 1/10/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 01/1/13 through 01/10/14. The review indicated the following for client #7.</p> <p>-A 5/25/13 BDDS report for an incident on 5/25/13 at 12:10am, indicated at 12:20am (on 5/25/13) GHS (Group Home Staff) #5 notified RHM [RHM #6] (Residential Home Manager) that client #7 "had fallen asleep on the couch in the living room. [GHS #5] said that [GHS #5] had verbally prompted [client #7] to wake up and go to his bed for at least an hour. At this time, co working staff [GHS #11] came into the living room, grabbed [client #7] by his shirt and pulled [client #7] up. [GHS #5] reported that [GHS #11] was pulling really hard to get [client #7] to get up, like it was almost choking [client #7]. [GHS #5] reported there was a red mark on [client #7's] shoulder." The report indicated "a full investigation has been started" and GHS #11 was suspended pending the outcome of the investigation. The report indicated client #7 was assessed by the agency RN (Registered Nurse) who indicated a</p>						

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	<p>reddened area on client #7's neckline approximately two inches (2") long and a reddened area on client #7's right shoulder approximately one inch (1") in diameter.</p> <p>-A 5/31/13 Follow Up BDDS report to the 5/25/13 allegation indicated "Allegation of Physical Abuse was substantiated. Staff accused of physical abuse has been terminated" from employment.</p> <p>On 1/17/14 at 2:35pm, an interview with the Director of Group Home Living (DGHL) was conducted. The DGHL stated staff was suspended "after she became aware of the incident after 1pm" on 5/25/13. The DGHL indicated on 5/25/13 GHS #11 continued to work and finished her shift of work at the group home with client #7 and clients #1, #2, #3, #4, #5, #6, and #8 present at the group home. The DGHL indicated the facility staff the allegation was reported to the residential manager. The DGHL indicated the residential manager did not report it to the office or take proactive measures to protect client #7 at 12:20am on 5/25/13 when made aware of the incident. The DGHL stated "No, [GHS #11] was not immediately suspended." The DGHL indicated the facility staff did not implement the facility's policy</p>			

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W000154	<p>and procedure to protect client #7 from substantiated staff abuse.</p> <p>9-3-1(b)(5) 9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, for 2 of 2 BDDS (Bureau of Developmental Disabilities Services) reports (clients #1 and #7) reviewed of allegations of staff abuse, neglect, and/or mistreatment, the facility failed to implement the facility's policy and procedure to thoroughly investigate allegations of staff abuse, neglect, and/or mistreatment.</p> <p>Findings include:</p> <p>1. On 1/10/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 01/1/13 through 01/10/14. The review indicated the following for client #1.</p> <p>-A 11/12/13 BDDS report for an incident reported on 11/11/13 for an incident on 11/9/13 at 6pm. The BDDS report indicated during a group outing in</p>	W000154	<p>Staff will be retrained on the supervision needs for client's#1, 7 on February 16, 2014. To ensure that investigations are implemented immediately, QDDP, residential house manager, and residential nurse will be retrained on the agency policy on investigations (Appendix R) which includes immediately suspending the staff in question in order to protect the consumer.</p> <p>To ensure that all investigations are thorough and complete, the investigation documentation process has been revised to include the following elements: an interview form (Appendix S) that includes name of interviewee, name of interviewer, date of interview, and signature line. To ensure sufficient corrective action following an incident, the investigation documentation was revised to require the investigator to include a more detailed summary of events (leading up to the incident, during the incident,</p>	02/16/2014	

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	<p>the community "an employee from a different [agency name] program happened to be at the same [store] and noticed [client #1] by herself and crying. Staff member approached [client #1] and asked her what was wrong and [client #1] told that staff member that she could not find her staff and was lost. The employee then had the staff paged that [client #1] said was with her and the other consumers during this outing." The report indicated GHS (Group Home Staff) #10 was suspended pending an investigation.</p> <p>-The 11/11/13 investigation indicated clients #1, #2, #3, #6, #7, and #8 went with GHS #2, GHS #4, and GHS #10 to an outside mall area shopping. The investigation indicated "staff reported that [GHS #10] did not supervise [client #1] during a group outing." The investigation indicated "Upon completion of investigation of neglect, writer feels that neglect can be substantiated in this case for all staff members present during the group outing on 11/9/13. The consumer, [client #1], has a history of elopement and has a BSP (Behavior Support Plan) that addresses elopement as well as should remain within the line of sight of all staff. During review with consumer [client #8] he stated that [client #1] was</p>		<p>after the incident) section (Appendix T). The revised documentation also requires the investigator to specify recommendations including actions to prevent occurrence (Appendix T), corrective action (action taken besides staff discipline as a response to the incident) (Appendix T). The QDDP, house manager, and lead staff supervisor will be trained 2/16/14. To ensure monitoring of this process, the QDDP will be required to report to Vice President of Residential Services, a summary of IDT meeting following a report of ANE. Further, the Lead Staff Supervisor, who has the primary responsibility for conducting investigations, will submit investigation material to VP for review to ensure all elements are included.</p>				

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	<p>in [GHS #10's] group with him (client #8) and furthermore [client #8] stated that [GHS #10] was aware of [client #1] wondering (sic) off and continued to walk on. Writer interviewed consumer [client #1] and she stated that she was in [GHS #10's] group and that she wandered off and got lost. Therefore, the allegation of neglect can be substantiated." The investigation did not document recommendations for corrective action for the substantiated neglect; for retraining on client #1's supervision needs; or retraining staff for reporting allegations immediately to the administrator and/or to BDDS in accordance with State Law.</p> <p>On 1/17/14 at 2:35pm, an interview with the Director of Group Home Living (DGHL) was conducted. The DGHL stated "It was substantiated neglect" when client #1 was not supervised in the community by the staff who were responsible for her. The DGHL indicated the investigation did not include recommendations to retrain staff for reporting allegations.</p> <p>2. On 1/10/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 01/1/13 through 01/10/14. The review indicated the</p>						

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	<p>following for client #7.</p> <p>-A 5/25/13 BDDS report for an incident on 5/25/13 at 12:10am, indicated at 12:20am (on 5/25/13) GHS (Group Home Staff) #5 notified RHM [RHM #6] (Residential Home Manager) that client #7 "had fallen asleep on the couch in the living room. [GHS #5] said that [GHS #5] had verbally prompted [client #7] to wake up and go to his bed for at least an hour. At this time, co working staff [GHS #11] came into the living room, grabbed [client #7] by his shirt and pulled [client #7] up. [GHS #5] reported that [GHS #11] was pulling really hard to get [client #7] to get up, like it was almost choking [client #7]. [GHS #5] reported there was a red mark on [client #7's] shoulder." The report indicated "a full investigation has been started" and GHS #11 was suspended pending the outcome of the investigation. The agency RN (Registered Nurse) indicated a reddened area on client #7's neckline approximately two inches (2") long and a reddened area on client #7's right shoulder approximately one inch (1") in diameter.</p> <p>-A 5/31/13 Follow Up BDDS report to the 5/25/13 allegation indicated "Allegation of Physical Abuse was</p>						

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	<p>substantiated. Staff accused of physical abuse has been terminated" from employment.</p> <p>On 1/17/14 at 2:35pm, an interview with the Director of Group Home Living (DGHL) was conducted. The DGHL stated staff was suspended "after she became aware of the incident after 1pm" on 5/25/13. The DGHL indicated no written investigation into client #7's incident on 5/25/13 was available for review. The DGHL stated the BDDS report was "our investigation until we attended the State of Indiana Abuse, Neglect, and Mistreatment Investigative Training provided within the past three months or so." The DGHL indicated no documented recommendations for immediately reporting allegations of abuse, neglect, and/or mistreatment, protecting the clients from the potential of further abuse, completing a thorough investigation, documenting client witness statements, documenting staff witness statements, and/or documenting the results and recommendations of the investigation.</p> <p>9-3-2(a)</p>				

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W000155	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview, for 2 of 2 BDDS (Bureau of Developmental Disabilities Services) reports (clients #1 and #7) reviewed of allegations of staff abuse, neglect, and/or mistreatment, the facility failed to implement the facility's policy and procedure to prohibit staff abuse, neglect, and/or mistreatment and failed to protect clients #1 and #7 from the potential of further staff abuse, neglect, and/or mistreatment when clients #1 and #7 had identified needs.</p> <p>Findings include:</p> <p>1. On 1/10/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 01/1/13 through 01/10/14. The review indicated the following for client #1.</p> <p>-A 11/12/13 BDDS report for an incident reported on 11/11/13 for an incident on 11/9/13 at 6pm. The BDDS report indicated during a group outing in the community "an employee from a different [agency name] program happened to be at the same [store] and noticed [client #1] by herself and crying. Staff member approached [client #1]</p>	W000155	To ensure that consumers are protected from further potential abuse while the investigation is in progress, all staff will follow the agency investigatory leave policy (Appendix R) which states that the accused staff are immediately suspended pending investigation. Residential QDDP, residential house manager, and residential nurse will be retrained on this policy 2/16/14. Bona Vista has a policy on the prevention of abuse, neglect, and mistreatment (Appendix N). All staff will be retrained on this policy. Further, staff will be retrained on BDDS reporting guidelines including immediately reporting any instance of ANE immediately to management (Appendix O). Bona Vista has a progressive disciplinary policy (Appendix P) for staff who fail to report immediately, and staff will be retrained on this policy on 2/16/14. For continued monitoring, the policy on ANE, immediate reporting, and prohibition of violation of rights was added to the annual compliance tracking (Appendix Q) and every staff will receive training two times per year on these topics. Staff will be retrained on the supervision needs for client's #1, 7 on February 16, 2014.	02/16/2014			

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	<p>and asked her what was wrong and [client #1] told that staff member that she could not find her staff and was lost. The employee then had the staff paged that [client #1] said was with her and the other consumers during this outing." The report indicated GHS (Group Home Staff) #10 was suspended pending an investigation.</p> <p>-The 11/11/13 investigation indicated clients #1, #2, #3, #6, #7, and #8 went with GHS #2, GHS #4, and GHS #10 to an outside mall area shopping. The investigation indicated "staff reported that [GHS #10] did not supervise [client #1] during a group outing." The investigation indicated "Upon completion of investigation of neglect, writer feels that neglect can be substantiated in this case for all staff members present during the group outing on 11/9/13. The consumer, [client #1], has a history of elopement and has a BSP (Behavior Support Plan) that addresses elopement as well as should remain within the line of sight of all staff. During review with consumer [client #8] he stated that [client #1] was in [GHS #10's] group with him (client #8) and furthermore [client #8] stated that [GHS #10] was aware of [client #1] wondering (sic) off and continued to walk on. Writer interviewed consumer</p>						

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	<p>[client #1] and she stated that she was in [GHS #10's] group and that she wandered off and got lost. Therefore, the allegation of neglect can be substantiated."</p> <p>On 1/17/14 at 2:35pm, an interview with the Director of Group Home Living (DGHL) was conducted. The DGHL stated "It was substantiated neglect" when client #1 was not supervised in the community by the staff who were responsible for her. The DGHL indicated staff did not immediately report the allegation until 11/11/13. The DGHL indicated the facility staff did not protect client #1 from further neglect when they failed to immediately report the incident. The DGHL indicated GHS #10 continued to work at the group home between 11/9/13 until 11/11/13. The DGHL stated client #1 did not possess community safety skills and was to have been within eye sight by the staff "at all times" while in the community. The DGHL indicated the investigation substantiated neglect by staff.</p> <p>2. On 1/10/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 01/1/13 through 01/10/14. The review indicated the following for client #7.</p>			

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	<p>-A 5/25/13 BDDS report for an incident on 5/25/13 at 12:10am, indicated at 12:20am (on 5/25/13) GHS (Group Home Staff) #5 notified RHM [RHM #6] (Residential Home Manager) that client #7 "had fallen asleep on the couch in the living room. [GHS #5] said that [GHS #5] had verbally prompted [client #7] to wake up and go to his bed for at least an hour. At this time, co working staff [GHS #11] came into the living room, grabbed [client #7] by his shirt and pulled [client #7] up. [GHS #5] reported that [GHS #11] was pulling really hard to get [client #7] to get up, like it was almost choking [client #7]. [GHS #5] reported there was a red mark on [client #7's] shoulder." The report indicated "a full investigation has been started" and GHS #11 was suspended pending the outcome of the investigation. The agency RN (Registered Nurse) indicated a reddened area on client #7's neckline approximately two inches (2") long and a reddened area on client #7's right shoulder approximately one inch (1") in diameter.</p> <p>-A 5/31/13 Follow Up BDDS report to the 5/25/13 allegation indicated "Allegation of Physical Abuse was substantiated. Staff accused of physical abuse has been terminated" from</p>			

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W000157	<p>employment.</p> <p>On 1/17/14 at 2:35pm, an interview with the Director of Group Home Living (DGHL) was conducted. The DGHL stated staff was suspended "after she became aware of the incident after 1pm" on 5/25/13. The DGHL indicated on 5/25/13 GHS #11 continued to work and finished her shift of work at the group home with client #7 and clients #1, #2, #3, #4, #5, #6, and #8 present at the group home. The DGHL indicated the facility staff reported the allegation to the residential manager. The DGHL indicated the residential manager did not report it to the office or take proactive measures to protect client #7 at 12:20am on 5/25/13 when notified of the incident. The DGHL stated "No, [GHS #11] was not immediately suspended."</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 2 of 2 BDDS (Bureau of Developmental Disabilities Services) reports (clients #1 and #7) reviewed of allegations of staff abuse, neglect, and/or mistreatment, the facility failed to implement sufficient corrective action to</p>	W000157	To ensure sufficient corrective action following an incident, the investigation documentation was revised to require the investigator to include a more detailed summary of events (leading up to the incident, during the incident, after the incident) section	02/16/2014			

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	<p>retrain the staff on immediately reporting, preventing abuse, neglect, and/or mistreatment, and client supervision needs for clients #1 and #7.</p> <p>Findings include:</p> <p>1. On 1/10/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 01/1/13 through 01/10/14. The review indicated the following for client #1.</p> <p>-A 11/12/13 BDDS report for an incident reported on 11/11/13 for an incident on 11/9/13 at 6pm. The BDDS report indicated during a group outing in the community "an employee from a different [agency name] program happened to be at the same [store] and noticed [client #1] by herself and crying. Staff member approached [client #1] and asked her what was wrong and [client #1] told that staff member that she could not find her staff and was lost. The employee then had the staff paged that [client #1] said was with her and the other consumers during this outing." The report indicated GHS (Group Home Staff) #10 was suspended pending an investigation and "all" staff in the home will be retrained on the importance of providing a safe and secure environment for the consumers as well as responding</p>		<p>(Appendix T). The revised documentation also requires the investigator to specify recommendations including actions to prevent occurrence (Appendix T), corrective action (action taken besides staff discipline as a response to the incident) (Appendix T). The QDDP, house manager, and lead staff supervisor will be trained 2/16/14. To ensure monitoring of this process, the QDDP will be required to report to Vice President of Residential Services, a summary of IDT meeting following a report of ANE. Further, the Lead Staff Supervisor, who has the primary responsibility for conducting investigations, will submit investigation material to VP for review to ensure all elements are included.</p>				

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	<p>appropriately to the needs of those consumers. No documented proof of this corrective action was available for review.</p> <p>-The 11/11/13 investigation indicated clients #1, #2, #3, #6, #7, and #8 went with GHS #2, GHS #4, and GHS #10 to an outside mall area shopping. The investigation indicated "staff reported that [GHS #10] did not supervise [client #1] during a group outing." The investigation indicated "Upon completion of investigation of neglect, writer feels that neglect can be substantiated in this case for all staff members present during the group outing on 11/9/13. The consumer, [client #1], has a history of elopement and has a BSP (Behavior Support Plan) that addresses elopement as well as should remain within the line of sight of all staff. During review with consumer [client #8] he stated that [client #1] was in [GHS #10's] group with him (client #8) and furthermore [client #8] stated that [GHS #10] was aware of [client #1] wondering (sic) off and continued to walk on. Writer interviewed consumer [client #1] and she stated that she was in [GHS #10's] group and that she wandered off and got lost. Therefore, the allegation of neglect can be substantiated." The investigation did</p>				

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	<p>not document proof for corrective action for the substantiated neglect, did not indicate proof of corrective action for retraining on client #1's supervision needs, did not indicate staff retraining on reporting the allegation immediately to the administrator and/or to BDDS in accordance with State Law.</p> <p>On 1/17/14 at 2:35pm, an interview with the Director of Group Home Living (DGHL) was conducted. The DGHL stated "It was substantiated neglect" when client #1 was not supervised in the community by the staff who were responsible for her. The DGHL indicated staff did not report the 11/9/13 allegation until 11/11/13. The DGHL indicated the facility staff did not protect client #1 from the potential for further neglect when they failed to immediately report the incident. The DGHL indicated no corrective action was available for review in regards to staff retraining for immediate reporting allegations/incidents and client #1's supervision needs in the community.</p> <p>2. On 1/10/14 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 01/1/13 through 01/10/14. The review indicated the following for client #7.</p>						

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W000227	<p>employment.</p> <p>On 1/17/14 at 2:35pm, an interview with the Director of Group Home Living (DGHL) was conducted. The DGHL stated staff was suspended "after she became aware of the incident after 1pm" on 5/25/13. The DGHL indicated the facility staff reported the allegation to the residential manager. The DGHL indicated the residential manager did not report it to the office or take proactive measures to protect client #7 at 12:20am on 5/25/13. The DGHL stated "No, [GHS #11] was not immediately suspended." The DGHL indicated no written investigation into client #7's incident on 5/25/13 was available for review. The DGHL indicated no documented corrective action was available for review for: immediately reporting allegations of abuse, neglect, and/or mistreatment and protecting the clients from the potential of further abuse.</p> <p>9-3-2(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.</p>			
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	<p>Based on observation, interview, and record review for 2 of 4 sampled clients (clients #1 and #4), the facility failed to initiate programming in client #1's Individual Support Plan (ISP) which incorporated dental recommendations into client #1's toothbrushing objective and failed to address client #4's dressing for inclement weather.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 1/15/14 at 10:40am. Client #1's 4/4/13 ISP (Individual Support Plan) indicated an objective to "thoroughly brush" her teeth daily and did not indicate an oral hygiene plan. Client #1's 3/28/13 dentist recommendation indicated a recommendation to "assist to brush (her teeth) twice daily." Client #1's 9/30/13 dentist recommendation indicated a recommendation to "assist to brush two times daily." Client #1's dental recommendations to manually assist client #1 twice daily were not incorporated into client #1's dental objective.</p> <p>On 1/17/14 at 2:35pm, an interview was conducted with the DGHL (Director of Group Home Living). The DGHL indicated no documentation was available for review to determine if</p>	W000227	<p>Client #1 has an oral hygiene protocol written to address oral hygiene recommendations from dentist (Appendix U). Her oral hygiene goal was revised to include the dentist recommendations (Appendix V), her risk assessment was updated to reflect the change (Appendix W) and her ISP was also revised (Appendix H). Staff will be trained 2/16/14. Client #4 has a program goal to dress appropriately for the weather (Appendix X). His risk assessment has been updated to reflect this need (Appendix Y) and his health and safety plan was revised (Appendix Z). All staff will be trained 2/16/14. To ensure continued monitoring of compliance, residential house managers review program goal documentation on a daily basis (Appendix M) to ensure that staff are implementing goals. This documentation is turned in weekly to Vice President for Residential Services for review.</p>	02/16/2014	

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	<p>action was taken for the 9/30/13 and/or the 3/28/13 dental recommendations. The DGHL indicated client #1 had an objective to thoroughly brush her teeth daily. The DGHL indicated client #1 did not have the recommendations by the dentist incorporated into client #1's toothbrushing objective.</p> <p>2. On 1/10/14 from 6:20am until 8:12am, client #4 exited the facility three times to smoke and did not wear a coat twice. Client #4 was not prompted and/or encouraged by the facility staff to wear a coat outside to smoke.</p> <p>On 1/13/14 from 2:45pm until 5:45pm, client #4 was observed at the group home. At 4:20pm, client #4 exited the bathroom, indicated he showered, and showed his wet hair dripping on his shirt under his seizure helmet. At 4:35pm, client #4 with wet hair exited the facility through the front door with the facility staff and client #7 to smoke outside. Client #4 did not wear a coat and was not prompted or encouraged to wear a coat outside. At 5:30pm, client #4 exited the facility through the back door to the patio, with three (3) facility staff at the dining room table in full view of the window, to smoke and did not wear a coat. The temperature outside was thirty-seven degrees with snow on the</p>			
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W000382	<p>ground.</p> <p>On 1/15/14 at 11:45am, client #4's record was reviewed. Client #4's 10/24/13 ISP (Individual Support Plan) and 10/2013 BSP (Behavior Support Plan) both did not indicate a goal to wear a coat or clothe himself for inclement weather. Client #4's record did not indicate if client #4 had the ability to identify when to dress for inclement weather outside. Client #4's record indicated he had a court appointed guardian.</p> <p>On 1/17/14 at 2:35pm, an interview the DGHL (Director of Group Home Living) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The DGHL and the QIDP both indicated client #4 did not have a goal to teach him how to dress for inclement weather when going outside to smoke.</p> <p>9-3-4(a)</p> <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, record review, and interview, the facility failed to keep medications locked/secured when not</p>	W000382	All staff will be retrained 2/15/14 on the agency medicationadministration policy which clearly states that all	02/16/2014			

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	<p>administered for 4 of 4 sampled clients (#1, #2, #3, and #4), and four additional clients (clients #5, #6, #7, and #8), who resided in the home.</p> <p>Findings include:</p> <p>On 1/10/14 from 6:20am until 8:12am, and on 1/13/14 from 2:45pm until 5:45pm, observations were conducted and clients #1, #2, #3, #4, #5, #6, #7, and #8 walked and/or accessed each room throughout the group home independently. On 1/10/14 from 6:20am until 7:55am, the file cabinet which stored/contained client #5's Novolog Insulin and syringes for Diabetes Mellitus and client #1, #2, #3, #4, #5, #6, #7, and #8's extra medication containers from the pharmacy was unlocked and each drawer was able to be opened. At 7:55am, GHS (Group Home Staff) #1 indicated the file cabinet where client #5's insulin and client #1, #2, #3, #4, #5, #6, #7, and #8's medications were stored was unlocked and not secured. GHS #1 indicated the cabinet should have been locked and secured. GHS #1 indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 and anyone in the group home had access to the unsecured medications inside the cabinet.</p> <p>On 1/14/14 at 3:35pm, the Residential</p>		<p>medications will be kept inlocked area (Appendix AA). To ensure compliance, the residential house manager will check the medication area daily to ensure that all meds are securely locked (Appendix BB).</p>				

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	<p>Manager (RM) stated the medication cabinets should be secured and kept locked when medications were not being readied for administration.</p> <p>An interview was conducted on 1/15/14 at 10:00am, with the agency RN (Registered Nurse) and the QIDP (Qualified Intellectual Disabilities Professional). The RN and the QIDP both indicated medications should be kept locked/secured when medications were not administered. The RN indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 had access to the medication cabinet. The RN indicated the facility followed "Living in the Community" for medication administration.</p> <p>On 1/15/14 at 10:00am, a record review of the facility's 2004 "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication," medication should be kept secure when not being administered.</p> <p>9-3-6(a)</p>						

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W000391	<p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, for 1 of 24 medications observed administered at the morning medication administration (client #5), the facility failed to ensure each medication was labeled.</p> <p>Findings include:</p> <p>On 1/10/14 at 6:48am, GHS (Group Home Staff) #1 and client #5 completed a blood sugar test which indicated a blood sugar level of 153. GHS #1 selected an unlabeled medication bottle of Novolog Insulin for Diabetes Mellitus, drew 6 units into a syringe, and handed the prepared injection to #5 for his administration into his right abdominal area. GHS #1 encouraged and instructed client #5 to inject the unlabeled insulin. At 7:10am, GHS #1 indicated the Novolog Insulin was unlabeled and was not identified as belonging to client #5.</p> <p>At 7:10am, client #5's 1/2014 MAR (Medication Administration record) was reviewed and indicated "Novolog 100u/ML (units/milliliters), Blood Sugar 0-80=0, 80-150=4u, 151-200=6u, 201-250=8u, 251-300=10u,</p>	W000391	Client #5's Novolog bottle has been marked with the client's initials. The Novolog is stored in the original container with the appropriate pharmacy label. All staff will be retrained on medication administration policy (Appendix AA) which indicates that all medications can only be administered from pharmacy approved storage containers or packages with appropriate labeling that includes the name of the medication, the dosage, the route, the dates and times for administration and the date of expiration. To monitor for continued compliance, the Residential nurse or the Residential House Manager is required to review all medications for appropriate labeling and expiration dates. This will be documented (Appendix CC) and will be monitored as part of the monthly Periodic Service Review (Appendix DD).	02/16/2014			

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	<p>301-350=12u" for Diabetes Mellitus.</p> <p>On 1/10/14 at 7:10am, client #5's 11/2013 "Physician's Order" indicated "Novolog 100u/ML (units/milliliters), Blood Sugar 0-80=0, 80-150=4u, 151-200=6u, 201-250=8u, 251-300=10u, 301-350=12u" for Diabetes Mellitus.</p> <p>On 1/15/14 at 10:00am, an interview with the agency RN (Registered Nurse) was conducted. The RN indicated the agency staff followed the "Living in the Community: Core A/Core B" medication training. The RN stated "All medications should be labeled with a pharmacy label." The RN indicated client #5's insulin medication was not labeled. The RN indicated each medication should have client identification on each medication to signify it belonged to that client, a direction for the medication use, and open date if not replaced every thirty days.</p> <p>On 1/15/14 at 10:00am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled. The training manual</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/17/2014
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	<p>indicated each client's medication should be dated when the medication was opened.</p> <p>On 1/15/14 at 10:00am, a review of the facility's undated "Medication Administration Plan" indicated "Medications can only be administered from pharmacy approved storage containers or packages with appropriate labeling that includes the name of the medication, the dosage, the route of administration, the dates and times for administration and the date of expiration...Staff shall refer to the Medication Administration Record (MAR) and compare to the packaged medication to verify the medication, the time of administration, and the correct dosage."</p> <p>9-3-6(a)</p>			