

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  04/24/2012
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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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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: April 18, 19, 20, 23, and 24, 2012</p> <p>Surveyor: Kathy Craig, Medical Surveyor III</p> <p>Facility Number: 006630 Provider Number: 15G744 AIMS Number: 200902110</p> <p>These deficiencies also reflect state findings under 460 IAC 9.</p> <p>Quality review completed on May 1, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		

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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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #4), in obtaining a guardian for him.</p> <p>Findings include:</p> <p>Review on 4/19/12 at 1:40 PM of client #4's records was conducted. Client #4's ISP (Individual Support Plan) dated 7/15/11 indicated he had a health care representative but not a guardian. The ISP indicated by his birthdate he was over the age of 18 years. His ISP indicated he had a goal to identify a quarter from pieces of currency and "requires full assistance with financial management." Client #4's Comprehensive Functional Assistance dated 7/15/11 indicated assistance was required in regards to finances.</p> <p>Interview with the PD (Program Director) on 4/19/12 at 1:40 PM indicated client #4 could not make informed decisions regarding finances and they call client #4's mother, who is his healthcare</p>	W0125	<p>A lawyer has already been contacted regarding guardianship for Client #4. Requested paperwork has been submitted to the lawyer and payment for services has been collected. Client #4's Dr. has written a letter stating he is unable to attend the court hearing but the court date has not been set at this time. The parents, who are very involved in all aspects of decision making, were Health Care Representative and against becoming legal guardian because they felt it was unnecessary. The QDDP completes functional assessments annually to address the clients need for guardians. The need for guardian or HCR is reviewed annually at the ISP.</p>	06/29/2012			

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	<p>representative, about client #4's healthcare and finances. The PD indicated client #4's mother is in the process of obtaining guardianship.</p> <p>9-3-2(a)</p>				

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W0140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #4) by not keeping an accurate accounting of his cash on hand in the home.</p> <p>Findings include:</p> <p>Review on 4/18/12 at 4:35 PM of client #4's ledger dated April, 2012, indicated he was to have \$5.00 cash on hand. The actual cash on hand was \$3.00. There were no receipts to indicate where the other \$2.00 was.</p> <p>Interview on 4/18/12 at 4:40 PM with the house manager was conducted. The manager indicated staff had given client #4's mother \$20.00 for his haircut (the facility reimbursed her for the haircut) and she should have brought a receipt for a coke if she used the \$5.00 after the haircut to buy client #4 a coke.</p> <p>Interview on 4/20/12 at 2:45 PM with the PD (Program Director) was conducted. She indicated client #4's ledger should match his cash on hand.</p>	W0140	<p>The House Mgr will ensure that staff or parents bring receipts back for money that is given to them from the consumers personal cash on hand. The House Manager will be responsible to complete a budget sheet, attach receipts, and keep a ledger of expenditures. The staff will count the cash on hand at each shift change. A ledger is kept with the money to track the balance at all times. Receipts for items purchased are attached to the ledger and the ledger is attached to the budget sheet. The QDDP will be responsible to count the client funds on a monthly basis. Additionally the Social Service Coordinator will be responsible to count the funds for a second time in the same month while completing the Periodic Service Review (PSR).</p>	05/13/2012			

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W0149	<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.</p> <p>Based on record review and interview, the facility failed for 1 of 2 allegations of abuse reviewed by not reporting this incident immediately according to their abuse/neglect policy affecting 1 additional client (client #6).</p> <p>Findings include:</p> <p>Review on 4/18/12 at 2:05 PM of the facility's records included BDDS (Bureau of Developmental Disabilities Services) incident reports. A BDDS report dated 3/14/12 indicated on 3/12/12 at 7:00 PM the following: "On the evening of 3/12/2012 staff were assisting one consumer with a shower and another staff was passing medications. When staff went to the living room, it was found that the front door was open. [Client #6] was sitting outside on the ground. Upon assisting [client #6] up it was reported that one staff made derogatory (sic) comments to [client #6] regarding his disability."</p> <p>Review on 4/18/12 at 2:30 PM of the investigation dated 3/13/12 of the above incident indicated staff #1, who was working with staff #2, who allegedly</p>	W0149	All staff including Management and Direct Support staff hasbeen retrained on the importance of immediately contacting the supervisor wheneverallegations of abuse/neglect or misconduct by staff occurs. The staff was retrained on the BDDSreportable guidelines. The House Mgr. and QDDPunderstands the importance of reporting all incidents immediately. All residential QDDP's have been trained onthis procedure and will review at each group home. All employees will attend the agency wideBDDS reportable guidelines training annually in addition to their individualgroup home trainings. The Elder JusticeAct guidelines are posted in the group home for staff to review.	05/13/2012			

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	made the derogatory comments to client #6, called the house manager at 9:45 PM on 3/12/12 to report this incident. On 3/13/12, the PD called staff #1 at 2:00 PM for further questioning. The investigation indicated staff #1 "stated she did not like the way staff [name of staff #2] was speaking to the consumers. [Staff #1] reported that during dinner staff [name of staff #3] and [staff #2] assisted consumers with preparing plates. [Staff #3] then sat at the table with the consumers and assisted [client #6] in eating. [Staff #1] reported that after preparing her plate, [staff #2] went and sat on the couch with her food and watched television. It was reported that the only consumer in the living room with [staff #2] was [client #2]. [Staff #2] was holding the remote and had no interaction with [client #2] while in the room. [Staff #1] reported that [staff #3] began to assist consumers with cleaning up the kitchen. [Staff #2] told [staff #1] that she liked to work with [staff #3] because he does everything. She told her that "she didn't want to work with [staff #4] because she doesn't do anything." She reported that staff [name of staff #3] was passing evening medications to consumers and [staff #2] told [staff #1] to give a consumer a shower. [Staff #1] voiced that it was her first day and she was uncomfortable doing this task alone since she did not know the			

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	<p>consumers at this time. [Staff #1] then reported to QDDP (Qualified Developmental Disabilities Professional) that prior to his shower, [client #4] had a bm (bowel movement). [Staff #1] said his bottom wasn't wiped or prompted to wipe. The toilet became clogged from the bm. [Client #4] was assisted with his shower. After his shower, [staff #1] reported [staff #2] proceeded to direct him to sit on the toilet with bm in it because "if you sit him down he will dress himself." [Client #4] is legally blind. [Staff #2] assisted [staff #1] giving the shower. [Staff #1] then reported [staff #2] began walking around the house. Upon returning to the living room it was noted the front door was open. [Staff #1] reported [staff #2] shut the front door and stated "let's do a head count." Upon doing head count it was noted that [client #6] was gone. [Staff #2] and [staff #1] went outside and found [client #6] on the far side of the van laying on the ground. [Staff #2] proceeded to bring [client #6] up to the porch. [Staff #1] asked if he should be checked for bruises, [staff #2] replied "No, he falls all the time." [Staff #1] then asked if supervisors should be notified. [Staff #2] said no, m (sic) "Good thing he can't talk because he can't tell." Staff then sat outside with [client #6]. [Client #6] was handling his shoe string and attempting to hand it to staff.</p>						

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	<p>[Staff #1] reported that [staff #2] replied, "it's yours stupid." [Client #6] sat outside for a while. When he was ready to go in [staff #1] reported that [staff #2] said something to [client #6] about having a life then stated, "it's ok, he doesn't have one anyway." [Staff #1] reported to QDDP that she witnessed a lot of cussing by staff [name of staff #2] and that she didn't find it was appropriate in the group home." The BDDS report indicated staff was terminated because of verbal abuse.</p> <p>Review on 4/20/12 at 2:15 PM of the facility's abuse/neglect policy dated 5/11 was conducted. It indicated "It is the responsibility of any employee who possesses knowledge of an alleged case of neglect, battery, exploitation of a person, or psychological abuse to report it immediately, verbally and in writing, to the President or if the President is unavailable, the Senior Vice President. . ."</p> <p>Interview on 4/20/12 at 2:45 PM with the PD (Program Director) was conducted. The PD indicated staff are to report allegations of abuse/neglect immediately. The PD indicated staff #1 did not report this immediately to the on-call PD but waited until her shift was over. The administrator was not notified until the next day on 3/13/12.</p>			

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W0153	<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.</p> <p>Based on record review and interview, the facility failed for 1 of 2 allegations of abuse reviewed by not reporting this incident immediately affecting 1 additional client (client #6).</p> <p>Findings include:</p> <p>Review on 4/18/12 at 2:05 PM of the facility's records included BDDS (Bureau of Developmental Disabilities Services) incident reports. A BDDS report dated 3/14/12 indicated on 3/12/12 at 7:00 PM the following: "On the evening of 3/12/2012 staff were assisting one consumer with a shower and another staff was passing medications. When staff went to the living room, it was found that the front door was open. [Client #6] was sitting outside on the ground. Upon assisting [client #6] up it was reported that one staff made derogatory (sic) comments to [client #6] regarding his disability."</p> <p>Review on 4/18/12 at 2:30 PM of the investigation dated 3/13/12 of the above</p>	W0153	<p>The Neglect, Battery and Exploitation of Individuals policy has been reviewed with the QDDP. The QDDP and House Manager have a copy of the BDDS reportable guidelines and have reviewed with all the direct care staff. The QDDP understands that incident reports must be reported immediately to the supervisor. The QDDP will complete a thorough investigation of injuries and abuse/neglect. The QDDP understands that if incidents fall into the guidelines of abuse/neglect/exploitation, they will be reported to APS and the police in addition to BDDS. Immediate action will be taken to ensure client safety when an injury has occurred. When a significant incident occurs, the IDT will meet in a timely manner to discuss possible solutions or causes to the problem.</p>	05/13/2012			

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	<p>incident indicated staff #1 who was working with staff #2, the one who allegedly made the derogatory comments to client #6, called the house manager at 9:45 PM on 3/12/12 to report this incident. On 3/13/12, the PD called staff #1 at 2:00 PM for further questioning. The investigation indicated staff #1 "stated she did not like the way staff [name of staff #2] was speaking to the consumers. [Staff #1] reported that during dinner staff [name of staff #3] and [staff #2] assisted consumers with preparing plates. [Staff #3] then sat at the table with the consumers and assisted [client #6] in eating. [Staff #1] reported that after preparing her plate, [staff #2] went and sat on the couch with her food and watched television. It was reported that the only consumer in the living room with [staff #2] was [client #2]. [Staff #2] was holding the remote and had no interaction with [client #2] while in the room. [Staff #1] reported that [staff #3] began to assist consumers with cleaning up the kitchen. [Staff #2] told [staff #1] that she liked to work with [staff #3] because he does everything. She told her that "she didn't want to work with [staff #4] because she doesn't do anything." She reported that staff [name of staff #3] was passing evening medications to consumers and [staff #2] told [staff #1] to give a consumer a shower. [Staff #1]</p>						

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	<p>sat outside with [client #6]. [Client #6] was handling his shoe string and attempting to hand it to staff. [Staff #1] reported that [staff #2] replied, "it's yours stupid." [Client #6] sat outside for a while. When he was ready to go in [staff #1] reported that [staff #2] said something to [client #6] about having a life then stated, "it's ok, he doesn't have one anyway." [Staff #1] reported to QDDP that she witnessed a lot of cussing by staff [name of staff #2] and that she didn't find it was appropriate in the group home." The BDDS report indicated staff was terminated because of verbal abuse.</p> <p>Interview on 4/20/12 at 2:45 PM with the PD (Program Director) was conducted. The PD indicated staff are to report allegations of abuse/neglect immediately. The PD indicated staff #1 did not report this immediately to the on-call PD but waited until her shift was over. The administrator was not notified until the next day on 3/13/12.</p> <p>9-3-2(a)</p>				