STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G802	A. BUILDING 00 B. WING	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the PCR (Post Certification Revisit) to the recertification and state licensure survey and to the Covid-19 focused infection control survey completed on 3/1/21. This visit was in conjunction with the PCR to the investigation of complaints #IN00329141 and #IN00346364 completed on 3/1/21. Dates of survey: 4/6/21, 4/7/21, 4/8/21 and 4/9/21 Facility Number: 012527 Provider Number: 15G802 AIM Number: 201024860 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/26/21.	W 0000		
W 0382 Bldg. 00	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 for 3 of 3 sampled clients (A, B and C) plus 5 additional clients (D, E, F, G, H), the facility failed to ensure the medications were secure when not being administered. Findings include: Observations were completed on 4/6/21 from 6:30 am through 8:00 am. At 6:38 am, the medication cabinet was left unlocked for 20 minutes. The	W 0382	The medication cabinet is to be locked at all times. The Residential nurse retrained all staff on locking the med cabinet and making sure that it is locked and secured at all times. The House Manager will do regular checks daily to ensure that the medication cabinet is locked and secure.	05/07/2021

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

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	cabinet was opened without keys present. At 7:02 am DSP (Direct Support Professional) #1 was interviewed and indicated the medication cabinet should never be left unlocked when medications are not being administered. This affected clients A, B, C, D, E, F, G, and H. On 4/6/21 at 8:35 am a review of an undated "Medication Administration Plan" indicated in section "Medication Storage" the following: "All medications are stored in the original labeled prescription container, in a locked area when stored at room temperature, in a locked container in the refrigerator if required, separately from non-medical items, and under prescribed conditions of temperature, light, humidity, and ventilation." RM (Resident Manager) was interviewed on 4/6/21 at 7:37 am. The RM indicated the medication cabinet should not be left unlocked and unattended. The RM indicated the only time the medication cabinet should be left unlocked was during medication administration. RN (Registered Nurse) was interviewed on 4/6/21 at 12:34 pm. The RN indicated the medication cabinet should only be unlocked while it is in use by a trained staff member. The RN indicated the medication cabinet should not be left unlocked unless medications are being administered. 9-3-6(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.			

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	Based on observation, record review, and interview for 2 of 3 sampled clients (A and C) plus 1 additional client (E), the facility failed to implement and prompt hand washing before medication administration in the group home to assist with preventing the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic. Findings include: Observations were completed on 4/6/21 from 6:30 am through 8:00 am. At 7:20 am Client E was called into the medication closet for his morning medication pass. Client E was not prompted to wash or sanitize his hands before he received his morning medications. At 7:25 am Client C was called into the medication closet for his morning medication pass. Client C was not prompted to wash or sanitize his hands before receiving his morning medications. At 7:30 am Client A was called into the medication closet for his morning medication pass. Client A was not prompted to wash or sanitize his hands for his morning medication pass. At 7:34 am DSP (Direct Support Professional) #5 was interviewed and indicated clients should be prompted to wash their hands before receiving their medications. On 4/6/21 at 8:34 am a review of 9/20 "COVID-19 Agency Response Plan" indicated in section labeled "Employees" the following: "Employees play a critical role in COVID-19 prevention efforts. In an effort to stop the spread of COVID-19, employees and persons served should follow the following guidance: Practice good hygiene. Employees should clean their hands often, either with an alcohol-based hand sanitizer or soap and water. Hand sanitizer should	W 0455	Bona Vista requires all staff and person served to wash their hands before giving and receiving medications. The Residential Nurse retrained all staff in the home on proper handwashing procedures. All staff in the home were retrained on proper sanitation procedures as well. The Residential Nurse and House Manager will ensure that proper sanitizing and handwashing is being done in the home on a daily basis.	05/07/2021

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	contain at least 60 percent to 95 percent alcohol, and employees should wash their hands with soap and water for at least 20 seconds. In addition, employees should avoid touching their face and cough into their arm." RM (Resident Manager) was interviewed on 4/6/21 at 7:37 am. The RM indicated all clients should be washing their hands at every opportunity. The RM indicated clients should be washing or sanitizing their hands before meals, snacks, receiving their medications, or after using the restroom. RN (Registered Nurse) was interviewed on 4/6/21 at 12:34 pm. The RN indicated clients should wash their hands or sanitize their hands before receiving their medications. The RN indicated clients should be washing their hands frequently and have access to hand sanitizer in lieu of washing their hands. This deficiency was cited on 3/1/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-7(a)			