STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G802	A. BUILDING -- B. WING	02/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 02/18/21 Facility Number: 012527 Provider Number: 15G802 AIM Number: 201024860 At this Emergency Preparedness survey, Bona Vista Programs Inc was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. At the time of the survey, the census was 8. Quality Review completed on 02/19/21	E 0000		
E 0007 Bldg. --	403.748(a)(3), 416.54(a)(3), 418.113(a)(3), 441.184(a)(3), 482.15(a)(3), 483.475(a)(3), 483.73(a)(3), 484.102(a)(3), 485.625(a)(3), 485.68(a)(3), 485.727(a)(3), 485.920(a)(3), 491.12(a)(3), 494.62(a)(3) EP Program Patient Population [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and			

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

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

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	continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.]			
	Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.475(a)(3). This deficient practice could affect all occupants. Findings include: Based on record review on 02/18/21 at 1:30 p.m. with the Vice President Community Living (VPCL) the emergency preparedness plan (EPP) did not address: a. What services facility would be able to provide. b. Delegations of authority.	E 0007	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. o Bona Vista Vice President created a section in the Life Safety Emergency Plan that addresses the client population, including but not limited to, persons at risk. This section also addresses the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice	03/18/2021

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BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

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	Based on interview concurrent with record review it was acknowledged by the VPCL, she could not find this information in the EPP. This was discussed with the VPCL during the exit conference.		for any client the facility identified as being affected. o The facility reviewed all clients, not only in this home but others, to ensure that this section will be updated in all individual house plans. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. o Created section E007 in the Life Safety Emergency Plan for the Westmorland Group Home. o Created section E007 in the Life Safety Emergency Plan for the remaining 7 Group Homes within Bona Vista. o Trained all staff on section E007. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **Monitoring should include:** o The Quality Assurance Coordinator will monitor the Life Safety Manual to ensure that section E007 is in the binder, during her quarterly PSR's. The Quality Assurance Coordinator will ensure that staff are trained on Section E007.	

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E 0015 Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs			

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	for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 02/18/21 at 1:35 p.m. with the Vice President of Community Living (VPCL) the emergency preparedness plan did not address: 1. Alternate sources of power and protection of provisions. 2. Temperatures to protect provisions.	E 0015	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. o Bona Vista Vice President created a section in the Life Safety Emergency Plan that addresses the provision of subsistence needs for staff and clients whether they evacuate or shelter in place include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal 2. Describe how the facility reviewed all clients in the facility that could be affected by the	03/18/2021

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	Based on interview concurrent with record review with the VPCL it was stated she did not believe this information was in the emergency preparedness plan. This was discussed with the VPCL during the exit conference.		same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. o The facility reviewed all clients, not only in this home but others, to ensure that this section will be updated in all individual house plans. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. o Created section E015 in the Life Safety Emergency Plan for the Westmorland Group Home. o Created section E015 in the Life Safety Emergency Plan for the remaining 7 Group Homes within Bona Vista. o Trained all staff on section E015. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **Monitoring should include:** o The Quality Assurance Coordinator will monitor the Life Safety Manual to ensure that section E015 is in the binder, during her quarterly PSR's. The Quality Assurance Coordinator will ensure that staff are trained on	

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			Section E015.	
E 0031 Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.			

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	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) Other sources of assistance (iii) The State Licensing and Certification Agency (iv) The State Protection and Advocacy Agency in accordance with 42 CFR 483.475(c)(2). This deficient practice could affect all occupants. Findings include: Based on record review on 02/18/21 at 1:38 p.m. with the Vice President Community Living (VPCL) the emergency preparedness plan (EPP) did not include how to communicate with: the Indiana Protection and Advocacy Services, or the Indiana Bureau of Development Disability Services. Based on interview concurrent with record review with the VPCL it was acknowledged the EPP did not include the means to communicate with these two agencies in the communication portion of the EPP.	E 0031	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. o Bona Vista Vice President created a section in the Life Safety Emergency Plan that addresses the communication plan which includes all of the following: Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. o The facility reviewed all clients, not only in this home but others, to ensure that this section will be updated in all individual house plans. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. o Created section E031 in the Life Safety Emergency Plan for the Westmorland Group Home. o Created section E031 in the Life Safety Emergency Plan for the remaining 7 Group Homes	03/18/2021

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			within Bona Vista. o Trained all staff on section E031. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **Monitoring should include:** o The Quality Assurance Coordinator will monitor the Life Safety Manual to ensure that section E031 is in the binder, during her quarterly PSR's. The Quality Assurance Coordinator will ensure that staff are trained on Section E031.	
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.			

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	(iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing			

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	services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness			

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	training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on			

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	the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 02/18/21 at 1:39 p.m. with the Vice President of Community Living (VPCL) the emergency preparedness policy (EPP) did not include verification of knowledge through testing. Based on interview concurrent with record review with the VPCL it was stated testing is not done at this time, but they intend to start	E 0037	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. o Bona Vista Vice President created a section in the Life Safety Emergency Plan that addresses the Training Program protocol to include: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must	03/18/2021

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	15G802	A. BUILDING -- B. WING	02/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	computer training on the EPP where tests will be given. This was discussed with the VPCL during the exit conference.		conduct training on the updated policies and procedures. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. o The facility reviewed all clients, not only in this home but others, to ensure that this section will be updated in all individual house plans. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. o Created section E037 in the Life Safety Emergency Plan for the Westmorland Group Home. o Created section E037 in the Life Safety Emergency Plan for the remaining 7 Group Homes within Bona Vista. o Trained all staff on section E037. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **Monitoring should include:** o The Quality Assurance Coordinator will monitor the Life	

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			Safety Manual to ensure that section E037 is in the binder, during her quarterly PSR's. The Quality Assurance Coordinator will ensure that staff are trained on Section E037.	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 02/18/21 Facility Number: 012527 Provider Number: 15G802 AIM Number: 201024860 At this Life Safety Code survey, Bona Vista Programs Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was fully sprinklered with a basement. The facility has a fire alarm system with smoke detection on all levels in the corridors, common living areas and hard wired smoke detectors in the client sleeping rooms. The attic was not used for living purposes, storage or fuel-fired equipment and was provided with a heat detection system to activate the fire alarm system. The facility has a capacity of 8	K 0000		

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	and had a census of 8 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 1.88. Quality Review completed on 02/19/21			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 4 of 4 fire extinguishers in the Med room were supported. NFPA 10, Standard for Portable Fire Extinguishers, 6.1.3.4 requires that portable fire extinguishers types shall be (1) secured on a hanger (2) in the bracket supplied by the manufacturer (3) in a listed bracket approved for such purpose (4) in cabinets or wall recesses. This deficient practice could affect all occupants. Findings include: Based on observation with the Vice President Community Living (VPCL) on 02/18/21 at 1:51 p.m., four fire extinguishers were setting on top of a file cabinet in the Med room and were unsupported. Based on interview at the time of observation, the VPCL acknowledged the portable fire extinguishers were unsupported.	K S100	Westmorland 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. o Bona Vista Vice President notified House Manager and VP of Facilities to determine a better mounting system for the Fire Extinguishers, as the wall mounts are not sufficient due to behaviors in this house. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.	03/18/2021

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	This was discussed with the VPCL during the exit conference.		o The facility reviewed all clients, and discovered alternative mounting systems for the Fire Extinguishers based upon the needs and behaviors in the house. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. o Tasked Maintenance with finding alternative mounting solutions for the Fire Extinguishers to ensure they are accessible and safely mounted. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **Monitoring should include:** o The Quality Assurance Coordinator will monitor the placement of all Fire Extinguishers to ensure they are in their mounts during her in home inspections at least quarterly.	
K S222 Bldg. 01	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened			

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	from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)			
	Based on observation and interview, the facility failed to ensure 1 of 3 exterior exit doors and 1 of 1 Staff office doors were provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect all occupants in the facility.	K S222	K0222 Westmorland 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Bona Vista Vice President contacted the Bona Vista Maintenance team to remove the slide bolt on the front door and replace the lock on the staff door as it has both a deadbolt and a knob lock. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice	03/18/2021

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	Findings include: Based on observation on 02/18/21 during the tour between 1:10 p.m. to 2:00 p.m.. with the Vice President Community Living (VPCL) the the front door required a number code to disengage a slide bolt to open the door. The Staff office door had a deadbolt and a knob lock. Both doors required more than one releasing operation to open the doors. This was acknowledged by the VPCL at the time of observation. This was discussed with the VPCL during the exit conference.		for any client the facility identified as being affected. a. The facility reviewed all clients, not only in this home but others, to ensure that this section will be updated in all individual house plans. Maintenance will investigate other options that are safe for our homes with elopement risks. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. Maintenance request to remove the slide bolt on the front door and that locks on the staff door. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **Monitoring should include:** o The Quality Assurance Coordinator will monitor the door latches during her monthly PSRs.	
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard			

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	for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15).			

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	12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system components in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 13.5.8 states all damaged or missing components noted during inspection shall be repaired or replaced in accordance with manufacturer's instructions. Section 13.6.3.1 states maintenance of all backflow prevention assemblies shall be conducted by a trained individual following the manufacturer's. This deficient practice could affect all clients in the facility.	K S353	K-S353 Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. o The VP of Community Living will reach out to Brenneco and the Bona Vista Maintenance Department to have Brenneco come back out to have the	03/18/2021

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	Findings include: Based on record review on 02/18/21 at 1:11 p.m. with the Vice President Community Living (VPCL) the Sprinkler Report dated 01/28/21 stated in the deficiency section: "Antifreeze tested to 31 degrees F and there is no way to test water flow as there no inspector's test." Based on interview, the VPCL stated she was unsure if the antifreeze for the sprinkler system had been recharged or if the water flow inspector's test had been remedied. This was discussed with the VPCL during the exit conference.		"Antifreeze tested to 31 degrees F and also test water flow" as there is no inspector's test. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. VP of Community Living will collaborate with the VP of Facilities to ensure that any discrepancies in the Brenneco tests are addressed in a timely fashion. b. VP of Facilities was contacted by Brenneco on March 8, 2021 in regard to completing the necessary antifreeze test. This will cost approximately $1700.00 and has been scheduled. Describe the procedure for implementing the acceptable POC for the specific deficiency cited. o The VP of Community Living will reach out to Brenneco and the Bona Vista Maintenance Department to have Brenneco come back out to have the "Antifreeze tested to 31 degrees F and also test water flow" as there is no inspector's test. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **Monitoring should include:**	

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			o The Quality Assurance Coordinator will monitor the Brenneco folder to ensure that each report has the appropriate ratings, during her quarterly PSR's.	
K S354 Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service 2012 EXISTING (Prompt) Where a required automatic sprinkler system is out of service for more than 10 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 33.2.3.5.3, 9.7.6.1, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy when the automatic sprinkler system is out of service for more than 10 hours in a 24-hour period. NFPA 25, 15.5.2 (4) requires where a required fire protection system is out of service for more than 10 hours in a 24-hour period, the impairment coordinator shall arrange for one of the following: (5) the fire department has been notified and (6) the insurance carrier, the alarm company, property owner or designated representative, and other authorities having jurisdiction have been notified. This deficient practice could affect all clients in the facility. Findings include: Based on record review on 02/18/21 at 1:40 p.m. with the Vice President Community Living	K S354	K0354 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. o Bona Vista Vice President created document K0354 for times when the Sprinkler System is Out of Service: Where a required automatic sprinkler system is out of service for more than 10 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to	03/18/2021

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	(VPCL), the facility provided a fire watch plan documentation but it was incomplete. The plan failed to include calling all entities back once the sprinkler system has been restored to normal. Based on interview during the record review, the VPCL confirmed the fire watch documentation provided did not address calling back all entities to inform them the sprinkler system was back to normal function. This was discussed with the VPCL during the exit conference.		service. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. The facility reviewed all clients, not only in this home but others, to ensure that this section will be updated in all individual house plans. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. Created section K0354 in the Life Safety Emergency Plan for the Westmorland Group Home. b. Created section K0354 in the Life Safety Emergency Plan for the remaining 7 Group Homes within Bona Vista. c. Trained all staff on section K0354. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **Monitoring should include:** o The Quality Assurance Coordinator will monitor the Life	

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			Safety Manual to ensure that section E037 is in the binder, during her quarterly PSR's. The Quality Assurance Coordinator will ensure that staff are trained on Section K0354.	
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 3 of 4 ground fault circuit interrupters (GFCI) tested worked properly to provide protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect clients and staff. Findings include: Based on observations on 02/18/21 at 2:15 p.m. with the Vice President of Community Living (VPCL) there was one GFCI receptacle in the Client restroom on the first floor to the right of	K S511	K0511 - Westmorland 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. o Bona Vista Vice President contacted the Bona Vista Maintenance team to replace the faulty GFCI outlet in the restroom on the first floor. Maintenance will also replace the two electrical receptacles to the left of the kitchen sink which were not GFCI protected. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. o The facility reviewed all GFCI outlets to ensure that these were	03/18/2021

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	15G802	A. BUILDING 01 B. WING	02/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the sink which when tested showed "open ground" and did not trip. Also, there were two electrical receptacles to the left of the kitchen sink which were not GFCI protected. Based on interview at the time of observations and test with the VPCL it was acknowledged the GFCI in the Client restroom needed attention and two GFCI receptacles needed to replace the two currently in use. This was discussed with the VPCL during the exit conference.		safe and working properly. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. o Maintenance replaced the GFCI outlet. Maintenance will test the GFCI outlets during their monthly preventative maintenance. o Maintenance replaced the two electrical receptacles to the left of the kitchen sink which were not GFCI protected. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **Monitoring should include:** o The Quality Assurance Coordinator will monitor the GFCI outlets during her monthly PSRs.	
K S711 Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan The administration of every resident board and care facility shall have in effect and available to all supervisory personnel written copies of a plan for protecting all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan shall include special staff response, including fire protection procedures needed to ensure the			

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	15G802	A. BUILDING 01 B. WING	02/18/2021

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

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	safety of any resident, and shall be amended or revised whenever any resident with unusual needs is admitted to the home. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff not less than every two months. A copy of the plan shall be readily available at all times within the facility. All residents participating in the emergency plan shall be trained in the proper actions to be taken in the event of fire. Training shall include proper actions to be taken if the primary escape route is blocked. If the resident is given rehabilitation or habilitation training, training in fire prevention and the actions to be taken in the event of a fire shall be part of the training program. Residents shall be trained to assist each other in case of fire to the extent that their physical and mental abilities permit them to do so without additional personal risk. 32.7.1, 32.7.2, 33.7.1, 33.7.2 Based on record review and interview, the facility failed to provide a written evacuation and relocation plan in the event of fire and failed to provide documentation of periodic staff instruction on the written fire plan not less than every two months for the protection of 08 of 8 clients. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review on 02/18/21 at 1:36 p.m. with the Vice President Community Living (VPCL), a written evacuation and relocation plan in the event of fire and periodic staff instruction on the written fire plan was not available for	K S711	KS711 Westmorland Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. o The facility reviewed all clients, not only in this home but others, to ensure that this section will be updated in all individual house plans. o Staff will participate in monthly trainings which include execution	03/18/2021

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	15G802	A. BUILDING 01 B. WING	02/18/2021

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

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	review. Based on interview at the time of record review, the VPCL could not locate a written evacuation and relocation plan and periodic staff instruction on the plan. This was discussed with the VPCL during the exit conference.		of the written evacuation and relocation plan in the event of a fire. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. · House Manager will run safety drills with staff. · House Manager will train staff on how to run safety drills. · Staff will complete written documentation on evacuation and relocation plans in the event of a fire. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **Monitoring should include:** o The Quality Assurance Coordinator will monitor staff trainings during her quarterly PSR's. o The Quality Assurance Coordinator will ensure that House Managers are trained on where to maintain documentation of staff trainings for Life Safety.	