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	07/15/2022

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 pre-determined full recertification and state licensure survey. Dates of survey: 7/11, 7/12, 7/13, 7/14, and 7/15/2022. 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 #39778 on 8/2/22.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 3 of 3 sampled clients (clients #1, #2, and #3) and 4 additional clients (clients #4, #5, #6, and #7), the facility's governing body failed to exercise operating direction over the facility to ensure maintenance and repairs were completed to the group home regarding painting the kitchen, upstairs living room, and dining room walls and clients #1 and #5's shared bedroom closet not having a door. Findings include: During the observation periods at the group home, on 7/11/2022 from 2:55pm until 5:55pm and on 7/12/2022 from 5:50am until 7:55am, clients #1,	W 0104	Corrective action (104) To ensure maintenance and repairs are completed in a timely manner, the following correction plan will be implemented: The maintenance department completes monthly checks of the home and completes documentation to show any repairs that need completed. Maintenance obtain quotes and submits them to the Director of facilities for approval and estimation to complete repairs. Director of Program Compliance is	08/10/2022

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	#2, #3, #4, #5, #6, and #7 walked independently throughout the dining room, living rooms, laundry room, kitchen, and the hallway areas of the group home. During the observation periods, the living room, kitchen, and dining room had multiple unfinished dry wall patches on the walls. The walls were discolored with the undercoat of paint visible on the walls in the upstairs living room, kitchen, and dining room of the facility. On 7/11/2022 at 4:10pm, DSP (Direct Support Professional) #8 stated the living room, dining room, and kitchen walls "had multiple" unfinished dry wall patch repairs that needed to be painted and the walls in the rooms "needed repainted because the previous paint could be seen bleeding through the current color" of paint on the wall. DSP #8 indicated the walls in the kitchen, dining room, and upstairs living room had black marks and gouges in the walls of the different rooms. On 7/11/2022 at 2:55pm, client #1 indicated he shared a bedroom with client #5. Client #1 showed his bedroom and stated, "I don't have a closet door, but that would be nice if I could put some of my stuff out of sight." Clients #1 and #5's shared bedroom had a double wide closet without a door. On 7/14/2022 at 9:15am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated he was unsure about any pending maintenance scheduled to be completed in the home. On 7/15/2022 at 4:00pm, an interview was conducted with the QIDP, Director of Program Compliance (DPC), and the DRS (Director of Residential Services). The DRS indicated the walls in the dining room, upstairs living room, and kitchen needed to be painted. The DRS indicated she was not aware clients #1 and #5 did not have		in communication with Director of Facilities regarding the walls that need painted. This task was started July 29 and is projected to be completed by 8/31/22. The closet doors will be added 8/16/22.	

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	a closet door in their shared bedroom. No maintenance records were provided for review. 9-3-1(a)			
W 0148 Bldg. 00	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. Based on observation, record review, and interview, for 1 of 7 allegations of abuse, neglect, and/or mistreatment reviewed (client #3), the facility failed to ensure client #3's guardian was notified of significant injuries/incidents regarding a burn which resulted in client #3 requiring medical interventions. Findings include: During the observation periods at the group home, on 7/11/2022 from 4:00pm until 5:55pm and on 7/12/2022 from 5:50am until 7:55am, client #3 was observed at the group home. On 7/11/2022 at 4:00pm, client #3 arrived to the group home with the LPN (Licensed Practical Nurse). Client #3 was assisted with walking up the driveway, down the sidewalk, and up the steps into the group home by DSP (Direct Support Professional) #8 and the LPN. DSP #8 retrieved a wheelchair inside the group home and from 4:00pm until 5:55pm client #3 used a wheelchair to access the group home. On 7/11/2022 at 4:10pm, an interview was conducted with the LPN. The LPN indicated client #3 had an appointment at his physician's	W 0148	Corrective Action W-0148 To ensure clients' guardians are notified of all incidents including significant injuries, the following correction plan will be implemented. The QIDP was retrained on Bona Vistas incident reporting process which states that all incident reports are to be reported to guardians within 24 hours. The training was documented by way of a signed record of training.	08/10/2022

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	office for the open wounds on his right foot. The LPN stated client #3 had been seen by the outpatient clinic for the wounds on his right foot "around 7/1/22 from a burn caused by the cement." The LPN stated client #3's injuries to his right foot were caused when client #3 "was allowed to leave the day program barefoot, walked out to the facility van, and staff noticed the burns on [client #3's] foot later after the burns became blisters." On 7/11/2022 at 2:40pm and on 7/11/2022 at 7:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Accident/Illness reports, and investigations were reviewed and did not include client #3's allegation of staff neglect on 6/29/2022. On 7/12/2022 at 10:00am, the QAC (Quality Assurance Coordinator) provided client #3's 6/29/2022 BDDS report at the request of the surveyor. On 7/12/2022 at 10:00am, the QAC provided portions of the ongoing investigation for client #3's 6/29/2022 injuries. The review indicated the following: -A 7/1/2022 BDDS report regarding client #3's allegation of staff neglect which resulted in injuries to his left (sic/right) foot on 6/29/2022 at 3:15pm indicated "Staff reported that when they arrived to pick up [client #3] from day programming, he came out of the building with no shoes or socks on. The pavement was hot due to the weather, and by the time house staff noticed he wasn't wearing anything on his feet, [client #3] had sustained a burn to the bottom of his left (sic/right) foot, resulting in three blisters. Plan to Resolve: Staff immediately cleaned [client #3's]			

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	foot, then applied bacitracin ointment and gauze. He was taken to [name of outpatient clinic] for follow up observation and care. At the clinic, staff cleaned his foot again, and retreated it with antibiotic ointment and fresh gauze. [Client #3] is to stay off his foot as much as possible and follow up with his physician. The residential nurse (LPN) will be setting up an appointment for him to follow up with his doctor." The BDDS report did not indicate client #3's guardian was notified. While the BDDS report indicated the injury was to client #3's left foot all documents and pictures of this injury were of client #3's right foot. -Client #3's 6/29/2022 at 3:15pm "Accident/Incident Report" included a picture of the bottom of client #3's right foot with two large blisters: one covering the pads on the bottom of his first and third toes. The third blister was open, red, the skin was peeling back to the edges of his right foot and the opened blister covered the center area of the width of his foot then extended in length from where his toes connect to the foot down past the center of the arch of his right foot. The report had the 7/1/2022 outpatient clinic visit attached which indicated client #3 was seen on "7/1/2022 at 1:44pm for First and Second Degree Burns on his foot. A burn occurs when skin is exposed to too much heat, sun, or harsh chemicals. A first degree burn is a superficial burn causes only redness, like a sunburn. It heals in a few days. A second degree burn, partial thickness burn, is deeper and causes a blister to form. This may take up to 2 weeks to heal." The report had "[name of town] weather history on 6/29/2022 at 2:56pm" which indicated the outside temperature "at 2:56pm was 85 degrees" Fahrenheit. The "Google.com website" indicated when the outside temperature was 85 degrees, the temperature of the cement would be "in excess of			

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	175 degrees" Fahrenheit. No notification of client #3's guardian was documented. On 7/14/2022 at 9:15am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP stated, "I did not notify [client #3's] guardian of the incident." On 7/13/2022 at 3:35pm, an interview was conducted with client #3's guardian. Client #3's guardian stated she "thought the group home called her immediately for accidents and incidents." Client #3's guardian indicated she was not aware of any recent doctor appointments and stated "I'm not aware of any blisters on his feet." Client #3's guardian stated, "He gets blisters around his feet sometimes from his leg braces." Client #3's guardian indicated she had not received any calls from the group home and the agency for over a month for any incidents and accidents. On 7/15/2022 at 4:00pm, an interview was conducted with the DRS (Director of Residential Services), the QIDP, the LPN, and the SDRP (Senior Director of Residential Programs). The four administrative staff indicated client #3's guardian had not been notified of the 6/29/2022 incident with injuries. 9-3-2(a)			
W 0149 Bldg. 00	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 observation, record review, and interview, for 1 of 7 allegations of abuse, neglect, and/or mistreatment reviewed (client #3), the	W 0149	=" " p=" "> =" " p=" "> Corrective action (149)	08/10/2022

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	facility failed to ensure staff followed the agency's policy and procedure to protect client #3 from staff neglect, to immediately report injuries to the administrator and to BDDS (Bureau of Developmental Disabilities Services), and to complete a thorough investigation within five (5) business days regarding a burn which resulted in client #3 requiring medical intervention. Findings include: During the observation periods at the group home, on 7/11/2022 from 4:00pm until 5:55pm and on 7/12/2022 from 5:50am until 7:55am, client #3 was observed at the group home. On 7/11/2022 at 4:00pm, client #3 arrived to the group home with the LPN (Licensed Practical Nurse). Client #3 was assisted with walking up the driveway, down the sidewalk, and up the steps into the group home by DSP (Direct Support Professional) #8 and the LPN. DSP #8 retrieved a wheelchair inside the group home and from 4:00pm until 5:55pm, client #3 used a wheelchair to access the group home. On 7/11/2022 at 4:10pm, an interview was conducted with the LPN. The LPN indicated client #3 had an appointment at his physician's office for the open wounds on his right foot. The LPN stated client #3 had been seen by the outpatient clinic for the wounds on his right foot "around 7/1/22 from a burn caused by the cement." The LPN stated client #3's injuries to his right foot were caused when client #3 "was allowed to leave the day program barefoot, walked out to the facility van, and staff noticed the burns on [client #3's] foot later after the burns became blisters". On 7/11/2022 at 2:40pm and on 7/11/2022 at 7:30pm, the facility's BDDS (Bureau of		=" " span=" ">To ensure accurate implementation of Bona Vistas and procedure to protect clients from staff abuse, neglect, and exploitation, to thoroughly investigate allegations of staff abuse, and to immediately report allegations of abuse, neglect, and exploitation to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law, the following correction plan will be implemented: The QIDP was retrained on Bona Vistas incident reporting policy which states that all incident reports are to be reported to BDDS within 24 hours. The training was documented by way of a signed record of training. The investigator was retrained on the investigation policy which states all allegations of abuse, neglect, mistreatment need to be investigated within 5 business days. The training was documented by way of a signed record of training.	

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	Developmental Disabilities Services) reports, Accident/Illness reports, and investigations were reviewed and did not include client #3's allegation of staff neglect on 6/29/2022. On 7/12/2022 at 10:00am, the QAC (Quality Assurance Coordinator) provided client #3's 6/29/2022 BDDS report at the request of the surveyor. The QAC indicated an investigation was opened into this allegation on 7/1/2022 and had not yet been completed. The QAC provided portions of the ongoing investigation for client #3's 6/29/2022 injuries. The review indicated the following: On 7/12/2022 at 10:00am, the QAC provided client #3's 6/29/2022 BDDS report and portions of the following investigation: A 7/1/2022 BDDS report regarding client #3's allegation of staff neglect which resulted in injuries to his "left foot" on 6/29/2022 at 3:15pm indicated "Staff reported that when they arrived to pick up [client #3] from day programming, he came out of the building with no shoes or socks on. The pavement was hot due to the weather, and by the time house staff noticed he wasn't wearing anything on his feet, [client #3] had sustained a burn to the bottom of his left foot, resulting in three blisters. Plan to Resolve: Staff immediately cleaned [client #3's] foot, then applied bacitracin ointment and gauze. He was taken to [name of outpatient clinic] for follow up observation and care. At the clinic, staff cleaned his foot again, and retreated it with antibiotic ointment and fresh gauze. [Client #3] is to stay off his foot as much as possible and follow up with his physician. The residential nurse (LPN) will be setting up an appointment for him to follow up with his doctor." No completed formal investigation was available for review. While the BDDS report indicated the injury was to client #3's			

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	left foot all documents and pictures of this injury were of client #3's right foot. -Client #3's 6/29/2022 at 3:15pm "Accident/Incident Report" indicated the administrator was not notified of the events on 6/29/2022 until 7/1/2022. The report included a picture of the bottom of client #3's right foot with two large blisters: one each covering the pads on the bottom of his first and third toes. The third blister was open, red, the skin was peeling back to the edges of his right foot and the opened blister covered the center area of the width of his foot then extended in length from where his toes connect to the foot down past the center of the arch of his right foot. The report had the 7/1/2022 outpatient clinic visit attached which indicated client #3 was seen on "7/1/2022 at 1:44pm for First and Second Degree Burns on his foot. A burn occurs when skin is exposed to too much heat, sun, or harsh chemicals. A first degree burn is a superficial burn causes only redness, like a sunburn. It heals in a few days. A second degree burn, partial thickness burn, is deeper and causes a blister to form. This may take up to 2 weeks to heal." The report had "[name of town] weather history on 6/29/2022 at 2:56pm" which indicated the outside temperature "at 2:56pm was 85 degrees" Fahrenheit. The investigation included a "Google.com website" indicated when the outside temperature was 85 degrees and the website indicated when the temperature outside temperature was 85 degrees the temperature of the cement would be "in excess of 175 degrees" Fahrenheit. No notification of client #3's guardian was documented on the report. On 7/11/2022 at 1:15pm, an interview was conducted with the DRS (Director of Residential Services) and the SDRP (Senior Director of			

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	Residential Programs). The DRS and the SDRP both indicated allegations of abuse, neglect, and/or mistreatment should be immediately reported to the administrator and to BDDS in accordance to State Law. The DRS and the SDRP indicated investigations should be initiated immediately upon notification of the incident/allegation and should be completed within 5 working days. On 7/14/2022 at 9:15am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the facility followed the BDDS reporting and investigating policy and procedure for immediately reporting to the administrator and to BDDS of incidents which result or have the potential to result in injuries. The QIDP indicated the facility staff did not follow the agency's policy and procedure to prohibit staff neglect. The QIDP indicated he filed a BDDS report as soon as he was notified of the incident on 7/1/2022. The QIDP indicated client #3 wore leg braces on both lower extremities to support his walking. The QIDP indicated he had no knowledge of the investigation into client #3's burns to his foot. On 7/14/2022 at 6:00pm, an interview was conducted with the LPN. The LPN indicated she was not notified of client #3's burn injuries from 6/29/2022 until 7/1/2022. The LPN indicated she was shown a picture of client #3's injuries to his right foot by the DRS (Director of Residential Services) on 7/1/2022 and the nurse went immediately to see client #3's foot injuries herself. The LPN stated, "I can't find anything in [client #3's] records except the accident/incident report and the BDDS report regarding his injuries. I've looked. I charted nursing notes once I became aware of the injuries." The LPN indicated client			

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	#3's record did not indicate staff had cleaned client #3's injuries, applied antibiotic ointment, applied gauze, called their supervisor to report the injuries before 7/1/2022, monitored client #3 for signs/symptoms of infection, and described his foot injuries. The LPN indicated client #3's 6/2022 MAR (Medication Administration Record), 7/2022 MAR, staff notes, body integrity sheets (assessments of client #3's body), and the house log sheets did not indicate client #3 had injuries identified and/or treatment was completed. The LPN stated, "Body integrity sheets are required to be filled out daily and were not." The LPN indicated she was recently hired by the agency and had not had an opportunity to review all of the clients records in the group homes. The LPN stated, "It's staff neglect. He should have never been allowed to walk outside on the hot cement barefoot on 6/29/2022." The LPN indicated client #3's day program classroom was in the back of the day program building and there were two locked doors for him to walk through with the staff before client #3 was able to walk outside of the day program building. The LPN indicated client #3 had been incontinent of urine at the day program, his shoes became wet on 6/29/2022, he was barefoot during the time of transport and stated, "Nobody noticed. Nobody thought to notice it was hot outside and [client #3] was barefoot on hot cement" when he walked outside with the facility staff. The LPN indicated client #3 had problems walking and wore lower leg supports to support his legs when he walked. The LPN indicated client #3's leg braces would have covered his feet and were designed to be worn with his shoes. The LPN stated, "Apparently nobody noticed he didn't have those on either because he was barefoot." On 7/11/2022 at 2:40pm, a record review of the			

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	facility's undated policy and procedures for Abuse, Neglect, and Exploitation indicated "Abuse, Neglect, Exploitation" neglect was defined as "failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social wellbeing. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment...." 9-3-2(a)			
W 0153 Bldg. 00	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 observation, record review, and interview, for 1 of 7 allegations of abuse, neglect, and/or mistreatment reviewed (client #3), the facility failed to immediately report injuries to the administrator and to BDDS (Bureau of Developmental Disabilities Services) regarding a burn which resulted in client #3 requiring medical interventions. Findings include: During the observation periods at the group home, on 7/11/2022 from 4:00pm until 5:55pm and on 7/12/2022 from 5:50am until 7:55am, client #3 was observed at the group home. On 7/11/2022 at 4:00pm, client #3 arrived to the group home with the LPN (Licensed Practical Nurse). Client #3 was assisted with walking up the driveway, down the sidewalk, and up the steps into the group home	W 0153	=" p="">
=" p="">
b="">
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=" p="">
=" span="">Corrective Action (153)
=" span="">To ensure the facility immediately accurately reports any allegations of abuse, neglect, and exploitation to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law, the following correction plan will be implemented:
b<="" p="">
The QIDP was retrained on Bona	08/10/2022

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BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

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	by DSP (Direct Support Professional) #8 and the LPN. DSP #8 retrieved a wheelchair inside the group home and from 4:00pm until 5:55pm, client #3 used a wheelchair to access the group home. On 7/11/2022 at 4:10pm, an interview was conducted with the LPN. The LPN indicated client #3 had an appointment at his physician's office for the open wounds on his right foot. The LPN stated client #3 had been seen by the outpatient clinic for the wounds on his right foot "around 7/1/22 from a burn caused by the cement." The LPN indicated client #3's injuries to his right foot were caused when client #3 "was allowed to leave the day program barefoot, walked out to the facility van, and staff noticed the burns on [client #3's] foot later after the burns became blisters" on client #3's right foot. On 7/11/2022 at 2:40pm and on 7/11/2022 at 7:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Accident/Illness reports, and investigations were reviewed and did not include client #3's allegation of staff neglect on 6/29/2022. On 7/12/2022 at 10:00am, the QAC (Quality Assurance Coordinator) provided client #3's 6/29/2022 BDDS report at the request of the surveyor. On 7/12/2022 at 10:00am, the QAC provided portions of the ongoing investigation for client #3's 6/29/2022 injuries and the review indicated the following. A 7/1/2022 BDDS report regarding client #3's allegation of staff neglect which resulted in injuries to his left foot on 6/29/2022 at 3:15pm indicated "Staff reported that when they arrived to pick up [client #3] from day programming, he came out of the building with no		Vistas incident reporting policy which states that all incident reports are to be reported to BDDS within 24 hours. The training was documented by way of a signed record of training.	

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	shoes or socks on. The pavement was hot due to the weather, and by the time house staff noticed he wasn't wearing anything on his feet, [client #3] had sustained a burn to the bottom of his left foot, resulting in three blisters. Plan to Resolve: Staff immediately cleaned [client #3's] foot, then applied bacitracin ointment and gauze. He was taken to [name of outpatient clinic] for follow up observation and care. At the clinic, staff cleaned his foot again, and retreated it with antibiotic ointment and fresh gauze. [Client #3] is to stay off his foot as much as possible and follow up with his physician. The residential nurse (LPN) will be setting up an appointment for him to follow up with his doctor." A review of the 7/1/2022 BDDS report indicated the incident occurred on 6/29/2022. The incident was not reported to BDDS within 24 hours. While the BDDS report indicated the injury was to client #3's left foot all documents and pictures of this injury were of client #3's right foot. On 7/11/2022 at 1:15pm, an interview was conducted with the DRS (Director of Residential Services) and the SDRP (Senior Director of Residential Programs). The DRS and the SDRP both indicated allegations of abuse, neglect, and/or mistreatment should be immediately reported to the administrator and to BDDS in accordance to State Law. On 7/14/2022 at 9:15am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the facility followed the BDDS reporting and investigating policy and procedure for immediately reporting to the administrator and to BDDS of an incident which resulted or have the potential to result in injuries. The QIDP indicated the facility staff did not follow the agency's policy			

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	and procedure to immediately report client #3's injuries. The QIDP indicated he filed a BDDS report as soon as he was notified of the incident on 7/1/2022. 9-3-2(a)			
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on observation, record review, and interview, for 1 of 7 allegations of abuse, neglect, and/or mistreatment reviewed (client #3), the facility failed to complete a thorough investigation within five (5) business days regarding a burn which resulted in client #3 requiring medical interventions. Findings include: During the observation periods at the group home, on 7/11/2022 from 4:00pm until 5:55pm and on 7/12/2022 from 5:50am until 7:55am, client #3 was observed at the group home. On 7/11/2022 at 4:00pm, client #3 arrived to the group home with the LPN (Licensed Practical Nurse). Client #3 was assisted with walking up the driveway, down the sidewalk, and up the steps into the group home by DSP (Direct Support Professional) #8 and the LPN. DSP #8 retrieved a wheelchair inside the group home and from 4:00pm until 5:55pm, client #3 used a wheelchair to access the group home. On 7/11/2022 at 4:10pm, an interview was conducted with the LPN. The LPN indicated client #3 had an appointment at his physician's	W 0156	Corrective Action (156) To ensure the facility thoroughly completes investigations regarding any allegation of staff abuse, neglect, mistreatment or exploitation, the following correction plan will be implemented. The investigator was retrained on the investigation policy which states all allegations of abuse, neglect, mistreatment need to be investigated within 5 business days. The training was documented by way of a signed record of training.	08/10/2022

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	office for the open wounds on his right foot. The LPN stated client #3 had been seen by the outpatient clinic for the wounds on his right foot "around 7/1/22 from a burn caused by the cement." The LPN indicated client #3's injuries to his right foot were caused when client #3 "was allowed to leave the day program barefoot, walked out to the facility van, and staff noticed the burns on [client #3's] foot later after the burns became blisters." On 7/11/2022 at 2:40pm and on 7/11/2022 at 7:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Accident/Illness reports, and investigations were reviewed and did not include client #3's allegation of staff neglect on 6/29/2022. On 7/12/2022 at 10:00am, the QAC (Quality Assurance Coordinator) provided client #3's 6/29/2022 BDDS report at the request of the surveyor. The QAC indicated an investigation was opened into this allegation on 7/1/2022 and had not yet been completed. The QAC provided portions of the ongoing investigation for client #3's 6/29/2022 injuries. The review indicated the following: On 7/12/2022 at 10:00am, the QAC provided portions of the ongoing investigation which included: the 7/1/2022 BDDS report regarding client #3's allegation of staff neglect which resulted in injuries to his left foot on 6/29/2022 at 3:15pm indicated "Staff reported that when they arrived to pick up [client #3] from day programming, he came out of the building with no shoes or socks on. The pavement was hot due to the weather, and by the time house staff noticed he wasn't wearing anything on his feet, [client #3] had sustained a burn to the bottom of his left foot,			

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	resulting in three blisters. Plan to Resolve: Staff immediately cleaned [client #3's] foot, then applied bacitracin ointment and gauze. He was taken to [name of outpatient clinic] for follow up observation and care. At the clinic, staff cleaned his foot again, and retreated it with antibiotic ointment and fresh gauze. [Client #3] is to stay off his foot as much as possible and follow up with his physician. The residential nurse (LPN) will be setting up an appointment for him to follow up with his doctor." No completed formal investigation was available for review. While the BDDS report indicated the injury was to client #3's left foot all documents and pictures of this injury were of client #3's right foot. On 7/11/2022 at 1:15pm, an interview was conducted with the DRS (Director of Residential Services) and the SDRP (Senior Director of Residential Programs). The DRS and the SDRP indicated investigations should be initiated immediately upon notification of the incident/allegation and should be completed within 5 working days. 9-3-2(a)			
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview, for 2 of 3 sampled clients (clients #2 and #3) and 1 additional client (client #5), the facility failed to ensure clients #2 and #5's ISP (Individual Support Plan) and Diabetes High Risk Plan included a blood sugar range regarding when to call the nurse and client #3's mobility risk plan included to wear shoes when walking.	W 0240	Corrective Action (240) To ensure client 2 and 5 risk plans included a blood sugar range and to ensure client 3 mobility risk plan included the use of wearing shoes, the following correction plans will be implemented: The QIDP updated the risk plans	08/10/2022

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	Findings include: 1. During the observation periods at the group home, on 7/11/2022 from 4:00pm until 5:55pm and on 7/12/2022 from 5:50am until 7:55am, client #3 was observed at the group home. On 7/11/2022 at 4:00pm, client #3 arrived to the group home with the LPN (Licensed Practical Nurse). Client #3 was assisted with walking up the driveway, down the sidewalk, and up the steps into the group home by DSP (Direct Support Professional) #8 and the LPN. DSP #8 retrieved a wheelchair inside the group home and from 4:00pm until 5:55pm, client #3 used a wheelchair to access the group home and had a bandage on his right foot. On 7/11/2022 at 4:10pm, an interview was conducted with the LPN. The LPN indicated client #3 had an appointment at his physician's office for the open wounds on his right foot. The LPN stated client #3 had been seen by the outpatient clinic for the wounds on his right foot "around 7/1/22 from a burn caused by the cement." The LPN indicated client #3's injuries to his right foot were caused when client #3 "was allowed to leave the day program barefoot, walked out to the facility van, and staff noticed the burns on [client #3's] foot later after the burns became blisters" on client #3's right foot. On 7/12/2022 at 10:00am, the QAC (Quality Assurance Coordinator) provided client #3's 6/29/2022 BDDS (Bureau of Developmental Disabilities Services) report at the request of the surveyor. The QAC provided portions of the ongoing investigation for client #3's 6/29/2022 injuries. The review indicated the following incident for client #3. A 7/1/2022 BDDS report regarding client #3's allegation of staff neglect		and retrained staff on all three risk plan updates. The trainings were documented by way of signed record of trainings.	

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	which resulted in injuries to his left foot on 6/29/2022 at 3:15pm indicated "Staff reported that when they arrived to pick up [client #3] from day programming, he came out of the building with no shoes or socks on. The pavement was hot due to the weather, and by the time house staff noticed he wasn't wearing anything on his feet, [client #3] had sustained a burn to the bottom of his left foot, resulting in three blisters. Plan to Resolve: Staff immediately cleaned [client #3's] foot, then applied bacitracin ointment and gauze. He was taken to [name of outpatient clinic] for follow up observation and care. At the clinic, staff cleaned his foot again, and retreated it with antibiotic ointment and fresh gauze. [Client #3] is to stay off his foot as much as possible and follow up with his physician. The residential nurse (LPN) will be setting up an appointment for him to follow up with his doctor." While the BDDS report indicated the injury was to client #3's left foot all documents and pictures of this injury were of client #3's right foot. -Client #3's 6/29/2022 at 3:15pm "Accident/Incident Report" included a picture of the bottom of client #3's right foot with two large blisters: one each covering the pads on the bottom of his first and third toes. The third blister was open, red, the skin was peeling back to the edges of his right foot and the opened blister covered the center area of the width of his foot then extended in length from where his toes connect to the foot down past the center of the arch of his right foot. Client #3's record was reviewed on 7/12/2022 at 10:10am and on 7/13/2022 at 12:15pm. Client #3's 7/5/2022 ISP (Individual Support Plan) indicated he wore lower leg orthotic braces to enable him to walk during waking hours because of Cerebral			

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	Palsy hemiplegia (weakness of the muscles) and was at risk to fall. Client #3's 3/7/2022 Mobility Risk Plan. Client #3's plans did not indicate he needed to wear shoes when walking. On 7/14/2022 at 9:15am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated he had helped to develop client #3's mobility risk plan and the plan did not include client #3 should wear shoes when walking. The QIDP stated, "I thought it was a no brainer." On 7/14/2022 at 6:00pm, an interview was conducted with the LPN. The LPN indicated client #3's leg braces would have covered his feet and were designed to be worn with his shoes. The LPN indicated client #3's ISP and mobility risk plan did not include he was to wear shoes when walking. 2. During the observation periods at the group home, on 7/11/2022 from 2:55pm until 5:55pm and on 7/12/2022 from 5:50am until 7:55am, client #5 was observed at the group home. On 7/11/2022 at 4:30pm, client #5 stated to the LPN "Hey, can I ask you something? What about my test strips for my blood sugar?" The LPN indicated to client #5 she had no knowledge regarding his test strips and asked client #5 why he was asking. Client #5 stated, "Well I haven't been able to test my blood sugar since Easter (4/17/2022) because we ran out of test strips and staff told me to wait." The LPN stated, "That's unacceptable. I will check on this." The LPN and DSP #8 checked in the medication room, the LPN reviewed client #5's 7/2022 MAR (Medication Administration Record) and physician order then indicated she would go get test strips for him to use. At 5:00pm, the LPN had returned to the group home with a box of			

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	blood sugar test strips and a new glucometer (to test blood sugar levels). The LPN indicated to the staff when a client runs out of supplies, the staff need to notify the nurse immediately. The LPN indicated client #5 was to test his blood sugar level every morning before breakfast. The LPN indicated client #5 should not have run out of supplies and nursing should have been aware of this before now. On 7/12/2022 at 7:10am, DSP #7 watched client #5 complete his blood sugar testing. At 7:10am, client #5 and DSP #7 stated client #5's blood sugar was "233." DSP #7 wrote down the blood sugar testing result in client #5's 7/2022 MAR. When asked what should client #5's blood sugar be, DSP #7 stated "That's not high for him. I've seen higher." DSP #7 indicated client #5's 7/2022 MAR did not include an acceptable range for his blood sugar and when the staff should contact the nurse regarding client #5's blood sugar level. Client #5's record was reviewed on 7/13/2022 at 2:00pm. Client #5's 6/27/2022 ISP (Individual Support Plan) and 1/22/2022 physician's order indicated he was a diabetic and was to complete daily blood sugar testing before breakfast. Client #5's 11/20/2019 "Diabetes Management Plan" indicated he was to test his blood sugar daily. Client #5's Diabetes Management Plan and 7/2022 MAR did not indicate an acceptable blood sugar range for client #5 and when staff were to call the nurse. On 7/14/2022 at 6:00pm, an interview was conducted with the LPN. The LPN indicated client #5's MAR and his Diabetes Management Plan did not include a range for the staff to know when to call the nurse. The LPN indicated the nurse was the responsible person to ensure staff			

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	have supplies including test strips to complete monitoring of blood sugars. 3. Client #2's record was reviewed on 7/12/2022 at 9:45am and on 7/13/2022 at 11:40am. Client #2's 7/6/2022 ISP and 1/22/2022 physician's order indicated client #2 was a Diabetic and "Check and record blood sugar every morning before breakfast." Client #2's record did not include a risk plan regarding his Diabetes Mellitus. On 7/14/2022 at 6:00pm, an interview was conducted with the LPN. The LPN indicated client #2 did not have a diabetic risk plan for how the staff were to monitor his blood sugars daily and a range for his blood sugar regarding when staff should contact the nurse. 9-3-4(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview for 1 additional client (client #5), the facility's nursing services failed to ensure sufficient oversight to ensure client #5 had test strips to monitor his blood sugar levels. Findings include: During the observation periods at the group home, on 7/11/2022 from 2:55pm until 5:55pm and on 7/12/2022 from 5:50am until 7:55am, client #5 was observed at the group home. On 7/11/2022 at 4:30pm, client #5 stated to the LPN (Licensed Practical Nurse), "Hey, can I ask you something? What about my test strips for my blood sugar?" The LPN indicated to client #5 she had no	W 0331	=" " p=" "> Corrective Action 331 To ensure clients have the appropriate amount of medications/medical supplies, the following correction plans will be implemented: =" " span=" ">All staff were retrained on ensuring there is adequate medications in the homes. The trainings were documented by way of signed record of trainings. =" " p=" ">	08/10/2022

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	knowledge regarding his test strips and asked client #5 why he was asking. Client #5 stated, "Well I haven't been able to test my blood sugar since Easter (4/17/2022) because we ran out of test strips and staff told me to wait." The LPN stated, "That's unacceptable. I will check on this." The LPN and DSP #8 checked in the medication room, the LPN reviewed client #5's 7/2022 MAR (Medication Administration Record) and physician orders then indicated she would go get test strips for him to use. At 5:00pm, the LPN had returned to the group home with a box of blood sugar test strips and a new glucometer (to test blood sugar levels). The LPN indicated to the staff when a client runs out of supplies, the staff need to notify the nurse immediately. The LPN indicated client #5 was to test his blood sugar level every morning before breakfast. The LPN indicated client #5 should not have run out of supplies and nursing should have been aware of this before now. Client #5's record was reviewed on 7/13/2022 at 2:00pm. Client #5's 6/27/2022 ISP (Individual Support Plan) and 1/22/2022 physician's orders indicated he was a diabetic and was to complete daily blood sugar testing before breakfast. Client #5's 7/2022 MAR did not indicate completed blood sugar testing. Client #5's 11/20/2019 "Diabetes Management Plan" indicated he was to test his blood sugar daily. On 7/14/2022 at 6:00pm, an interview was conducted with the LPN. The LPN indicated client #5 was a diabetic, on medication for his diabetes, and was to have had completed blood sugar monitoring daily before breakfast. The LPN indicated the nurse was the responsible person to ensure the staff have supplies including test strips to complete monitoring of blood sugars.			

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BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

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	9-3-6(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, for 1 of 3 sampled clients (client #3), the facility failed to follow client #3's physician's orders which resulted in a significant medication error. Findings include: On 7/11/2022 at 2:40pm and on 7/11/2022 at 7:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Accident/Illness reports, and investigations were reviewed and indicated the following medication error: -A 4/26/2022 BDDS report for a significant medication error on 4/25/2022 at 8:00am indicated client #3 "was inadvertently given [client #7's] medications during the 8:00am med. (medication) pass. Staff became distracted by other clients attempting to enter the med. room during administration of medications...Staff immediately notified [client #3's] doctor, who advised them to not administer any more medications to [client #3] until his next scheduled med. pass. He also instructed staff to watch [client #3] for any signs of physical pain or distress and to take him to the hospital if any were witnessed. Staff did not witness any ill effects from the incident." The report indicated "Plan to resolve: All staff are trained on how to administer medications properly and must pass Med. Core before doing so. The staff member involved in this incident has been	W 0368	Corrective Plan (368) To ensure medications are followed using the right client, right dose, right medication, right time, right date and right route the following correction plan will be implemented: All staff working in the home take a MedCore A and B course taught by an RN. The course is offered twice a month. Staff take a competency test at the end of the course. The MedCore certifications are tracked with the agency tracking system. All staff complete annual learning modules with competency tests on physical wellness including fatal five, personal care and safety protocols. All staff working in the home completed retraining on medication administration. the training was documented by way of a signed record of training. ="" span<="" p=""> ="" p=""> ="" span<="" p=""> ="" p=""> ="" p=""> ="" span<="" p="">	08/10/2022

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	reprimanded and retrained on proper medication administration protocol." The report did not include a list of the medication client #7 was prescribed at 8:00am medication pass. On 7/11/2022 at 7:30pm, client #7's 7/2022 MAR (Medication Administration Record) indicated the 8:00am medications prescribed on 4/15/2022 and administered to client #3 were: Multivitamin for nutritional health, Lisinopril 10mg (milligrams) for hypertension (high blood pressure), Divalproex 500mg for behaviors, Oxcarbazepine 600mg for seizure disorder, Lamotrigine 200mg for seizure disorder, Ziprasidone 80mg for behaviors, and Lithium 300mg for behaviors. On 7/14/2022 at 9:15am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the facility staff did not follow client #3's physician's orders. The QIDP stated the facility followed Core A/Core B for medication administration "which included staff administering medications according to the six rights of medication administration:...Right client, Right medication, Right dose, Right time...." On 7/14/2022 at 6:00pm, an interview was conducted with the LPN (Licensed Practical Nurse). The LPN stated the facility staff should follow the Core A/Core B medication administration training for medication administration "which included staff administering medications according to the six rights of medication administration:...Right client, Right medication, Right dose, Right time...." The LPN indicated client #3 was not prescribed the medications which were administered on 4/25/2022.			

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	9-3-6(a)			
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 (clients #1, #2, and #3) and 4 additional clients (clients #4, #5, #6, and #7), the facility failed to keep medications locked when not being administered. Findings include: During the observation period, on 7/11/2022 from 2:55pm until 5:55pm, clients #1, #2, #3, #4, #5, #6, and #7 were observed at the group home and independently accessed the hallway, living rooms, bathrooms, kitchen, dining room, and laundry room. On 7/11/2022 from 3:15pm until 3:50pm, the medication room door was open to the connecting hallway, no staff were present and the medication storage cabinet was unlocked. Clients #6 and #7's evening medications were on top of the unlocked medication cabinet and could be seen from the hallway. At 3:50pm, DSP (Direct Support Professional) #8 administered clients #6 and #7's evening medications. DSP #8 stated the medication cabinet "should have been locked." DSP #8 indicated the facility followed Core A/Core B medication administration training to keep medications locked when not being administered. DSP #8 indicated clients #1, #2, #3, #4, #5, #6, and #7's prescribed medications were stored inside the unlocked medication cabinet and clients #6 and #7's evening medications were on top of the unlocked medication cabinet. On 7/11/2022 at 4:00pm and on 7/14/2022 at	W 0382	Corrective Action (382) To ensure medication storage and labelling are followed correctly, the following correction plans will be implemented The House Manager will ensure that the medications are locked up in between each med pass. The House Manager will conduct monthly checks of all staff administering medications in the home to ensure competency of Core A and Core B medication administration. The nurse conducted a retraining of the Medication Administration Policy. The training is documented by way of signed record of training.	08/10/2022

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	6:00pm, interviews with the LPN (Licensed Practical Nurse) were conducted. LPN indicated the facility followed Core A/Core B medication administration training and the facility's medication administration policy and procedure. The LPN indicated medications should be kept locked when not being administered and when staff were not present within eye sight of the medications. On 7/14/2022 at 9:15am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the facility staff failed to follow Core A/Core B medication administration training when the medication cabinet and medications were left unlocked. The QIDP indicated medications should be kept locked when staff were not present and administering the medications. 9-3-6(a)			
W 0383 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and 4 additional clients (clients #4, #5, #6, and #7), the facility failed to ensure the medication keys were kept secured. Findings include: During the observation period, on 7/12/2022 from 5:50am until 7:55am, clients #1, #2, #3, #4, #5, #6, and #7 were observed at the group home. From 6:40am until 6:45am, the medication room keys hung on the medication room door without staff present. From 6:45am until 7:17am, the medication	W 0383	**W-0383** Corrective Action (383) To ensure medication keys are kept secure, the following correction plans will be implemented The nurse conducted a retraining of Medications and locked medications which included the security of medication keys. All staff were retrained in it. The training is documented by way of signed record of training.	08/11/2022

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	room keys were on top of a table in the living room without staff present. During the observation period, clients #1, #2, #3, #4, #5, #6, and #7 accessed each room, hallway, bedrooms, bathrooms, living room, dining room, and kitchen independently. On 7/12/2022 at 7:17am, DSP (Direct Support Professional) #7 indicated the facility followed Core A/Core B Medication Administration Training which indicated medication keys should be kept secured. On 7/14/2022 at 6:00pm, an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated the agency followed Core A/Core B Medication Administration Training to ensure medication keys were kept secured. The LPN indicated staff should have the keys on their person. 9-3-6(a)			
W 0407 Bldg. 00	483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together. Based on observation, record review, and interview, for 1 of 3 sample clients (client #1), the facility failed to ensure the housing environment met client #1's functional level, active treatment needs, and abilities to promote independence and learning. Findings include: During the observation periods at the group home, on 7/11/2022 from 2:55pm until 5:55pm and	W 0407	Corrective Action (407) Client 1 moved into a residential group home on 9/25/19. Client was awarded the SGL waiver from the state which placed him in the group home. At that time, client 1's guardian did not want Client 1 to be in supported living but wanted the group home setting. Due to Client 1's independence, his guardian has agreed to	08/10/2022

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	on 7/12/2022 from 5:50am until 7:55am, client #1 was independent with bathing, dressing, dining, leisure actives, and medication administration. On 7/11/2022 at 2:55pm, a community bus pulled up to the group home and client #1 exited the vehicle as DSP (Direct Support Professional) #7 pulled up to the group home in his personal car. At 2:55pm, DSP #7 indicated he had came into work because client #1 was due to arrive home from his community employment at a local store. At 2:55pm, client #1 was in his room at the group home. Client #1 was playing video games on the internet independently. Client #1 was soft spoken and stated, "I'm proud of myself. I take a lot of pride in my job. I've worked there a couple of years now." Client #1 indicated he went to the bank to make his withdrawals in person because he liked to do his banking independently. Client #1 indicated he arranged his own transportation on the community transit to/from work, liked to go on dates, liked to go do activities in the community, and needed staff to help him make good decisions. Client #1 showed his personal ID (Identification) and indicated he carried his wallet with him daily when he went to work or left the group home. Client #1 indicated he was working on setting up his own physician appointments. Client #1 stated, "No. I don't cook. The staff say that's their job." Client #1 indicated he would like to live in the community and stated, "I don't want to live by myself. I like people around." Client #1 had his own personal cell phone, tablet, and gaming system. On 7/11/2022 at 4:45pm, DSP #8 indicated client #1 completed tasks when staff made requests of him. When asked why client #1 lived in the group home, DSP #8 stated, "I don't know why." DSP #8 indicated client #1 was independent with bathing, dressing, writing, spelling, and stated, "He could cook and clean if he wanted to, but that's our job." DSP #8		proceed with the CIH waiver to place him in a Supported Living home where he will have a better opportunity for independence and learning. At this time, client 1 has applied for the CIH waiver and is pending approval.	

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	indicated client #1 at times needed verbal prompts to put on a sweater or reminded to use soap when bathing. On 7/14/2022 at 9:15am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated client #1 was independent with his daily care, arranging his transportation, bathing, dressing, leisure activities, and had limited behavioral episodes. The QIDP stated, "I'm not sure why [client #1] is in the group home." The QIDP indicated client #1 was not independent with cooking and cleaning. When asked if there was a process in place to move client #1 to a less restrictive environment, the QIDP stated, "I'm not aware if there is or not." The QIDP stated, "I'm not sure if [client #1] is appropriately placed at the group home." The QIDP indicated the former QIDP had left the agency's employment and did not document client #1's progression in client #1's record. Client #1's record was reviewed on 7/12/2022 at 10:45am and on 7/13/2022 at 1:00pm. Client #1's 6/29/2022 ISP (Individual Support Plan) and 6/29/2022 CFA (Comprehensive Functional Assessment) indicated his diagnoses included, but were not limited to: Autism, Pervasive Developmental Disorder, Bipolar Disorder, and ADHD (Attention Deficient Hyperactivity Disorder). Client #1's 6/29/2022 BSP (Behavior Support Plan) indicated targeted behaviors of lying, boundary issues, non compliance/refusal to follow directions, and a history of elopement. -Client #1's 6/29/2022 CFA indicated "he struggles with change" and he needed verbal prompts to dress for weather, to complete thorough brushing of his teeth, to remind him to use soap during			

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	showers, to complete household cleaning, and to stay on task. Client #1 was independent with spelling, pedestrian safety, community safety, and client #1's CFA indicated client #1 "was unable to be independent or make decisions of informed consent. [Client #1's] [name of family] are his guardians. They assist the interdisciplinary team when making major medical decision (sic)." Client #1's ISP indicated goals to contact transportation when he needed to go to work or an outing, to complete math equations of counting coins to one dollar, to write his address and telephone number, to brush his teeth thoroughly, to complete medication administration independently, and to participate in activities. On 7/15/2022 at 4:00pm, an interview was conducted with the DRS (Director of Residential Services), the QIDP, the LPN (Licensed Practical Nurse), and the SDRP (Senior Director of Residential Programs). The DRS, QIDP, and the SDRP indicated they were unsure if client #1 had a plan in place to move client #1 to a less restrictive environment. The DRS and SDRP indicated they were unsure what would be an appropriate process for client #1 to move forward. 9-3-7(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2,	W 0436	Corrective action (W0436) To ensure that clients are being	08/10/2022

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	and #3), the facility failed to have available and encourage clients #1, #2, and #3 to wear their prescribed eye glasses. Findings include: During the observation periods at the group home, on 7/11/2022 from 2:55pm until 5:55pm and on 7/12/2022 from 5:50am until 7:55am, clients #1, #2, and #3 were not encouraged by the facility staff to wear their prescribed eye glasses. During the observation periods, clients #1, #2, and #3 watched television, sat in chairs in the dining room to eat their meals and snacks, completed medication administration, bathed, used the rest room, played video games on their telephones/computer gaming systems, and the facility staff did not encourage clients #1, #2, and #3 to wear their prescribed eye glasses. Client #1's record was reviewed on 7/12/2022 at 10:45am and on 7/13/2022 at 1:00pm. Client #1's 6/29/2022 ISP (Individual Support Plan) did not indicate an objective for client #1 to wear his prescribed eye glasses. Client #1's ISP indicated he wore prescribed eye glasses. Client #1's 10/2/2019 vision evaluation indicated he wore prescribed eye glasses to see. Client #2's record was reviewed on 7/12/2022 at 9:45am and on 7/13/2022 at 11:40am. Client #2's 7/6/2022 ISP did not indicate an objective for client #2 to wear his prescribed eye glasses. Client #2's ISP indicated he "did not like to wear" his prescribed eye glasses. Client #2's 4/16/2019 vision evaluation indicated he wore prescribed eye glasses to see. Client #3's record was reviewed on 7/12/2022 at 10:10am and on 7/13/2022 at 12:15pm. Client #3's		encouraged to wear their prescribed eye glasses, the following corrective action will be completed: QIDP completed a retraining on Clients 1, 2 and 3 vision risk plan. All staff working in the home were retrained on the plan. No other clients were affected by the deficiency. Documentation will be maintained in way of signed records of training.	

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	6/4/2022 ISP did not indicate an objective for client #3 to wear his prescribed eye glasses. Client #3's ISP indicated he wore prescribed eye glasses. Client #3's 1/14/2021 vision evaluation indicated he wore prescribed eye glasses to see. On 7/14/2022 at 9:15am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated clients #1, #2, and #3 wore prescribed eye glasses to see. The QIDP indicated he was filling in as the QIDP for this home and stated "I'm unsure where their glasses are." The QIDP indicated the staff should have asked clients #1, #2, and #3 to wear their prescribed eye glasses when opportunities existed. On 7/14/2022 at 6:00pm, an interview was conducted with the LPN (Licensed Practical Nurse). The LPN indicated clients #1, #2, and #3 wore prescribed eye glasses to see. The LPN indicated she was not aware if clients #1, #2, and #3's prescribed eye glasses were available for their use. The LPN indicated the staff should have asked clients #1, #2, and #3 to wear their prescribed eye glasses. 9-3-7(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. Based on observation, record review, and interview for 3 of 3 sampled clients (clients #1, #2, and #3) and 4 additional clients (clients #4, #5, #6, and #7), the facility failed to implement and teach sanitary methods during meals and to implement the agency's Covid-19 (a respiratory illness)	W 0455	Corrective Action(s): 0455 To ensure COVID protocols, prevention and health measures are being taken Bona Vista will complete the following item(s): DSPs and House	08/10/2022

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	policy to screen visitors and to wear a face mask when opportunities existed to assist with preventing the spread of infection. Findings include: 1. During the observation periods at the group home, on 7/11/2022 from 2:55pm until 5:55pm and on 7/12/2022 from 5:50am until 7:55am, clients #1, #2, #3, #4, #5, #6, and #7's were observed at the group home. On 7/11/2022 at 3:15pm, clients #2, #3, #5, and #7 indicated to DSP (Direct Support Professional) #8 they wanted their snacks and the clients began going through the refrigerator, cabinets, and storage closet in the kitchen to look for their snack items. DSP #8 stated, "Well let's see." DSP #8 opened the freezer, and began talking out loud to list the items frozen inside the freezer. Clients #2, #3, and #7 indicated they would eat a chicken breast sandwich and french fries for their snack. DSP #8 removed the frozen breaded chicken breasts and a bag of french fries from the freezer and began to set the oven. DSP #8 baked chicken breasts and french fries in the oven while clients #2, #3, #5, and #7 stood watching and talking to DSP #8 while he cooked. At 4:15pm, DSP #8 indicated the snack food was done, clients #2 and #6 placed a bag of cut up lettuce in a bowl, client #2 set bottles of different sauces on the dining room table, and client #7 made koolaid in a pitcher. No clients were encouraged to wash their hands. At 4:15pm, clients #1, #2, #3, #5, #6, and #7 were served their snack by DSP #8 of a breaded chicken breast sandwich on two slices of bread and french fries. From 4:30pm until 5:00pm, DSP #8 served clients #1, #2, #3, #5, #6, and #7 a second sandwich of a breaded chicken patty and french fries. At 4:45pm, DSP #8 served client #3 a		Manager were retrained on the Agency COVID protocols, which include screening questions, temperature checks, social distancing, handwashing, and wearing a mask. A Record of Training was completed by all DSPs after a successful retraining, and the Record of Training will be kept in the employee's Human Resource File. The Agency Safety Coordinator will restock masks, screening questions, thermometer, and hand sanitizer in all the Group Homes. Director of program Compliance has included the training along with the certificated that all staff complete annually, or when important updates are made on the EFront training program. The EFront training as been added to the orientation classes ensuring that all staff are trained on it upon hire. ="" p=""> ="" p=""> ="" span=""> ="" p=""> ="" span=""> ="" span=""> ="" p="">	

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	15G802	A. BUILDING 00 B. WING	07/15/2022

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	third breaded chicken patty on two slices of bread and a third serving of french fries. During the observation period, clients #1, #2, #3, #5, #6, and #7 were not encouraged to wash their hands. 2. On 7/12/2022 from 5:50am until 7:55am an observation was conducted at the group home. DSP #2 and DSP #7 did not wear a face mask during the observation period. At 5:50am, the surveyor was allowed to enter the group home by DSP #2 and DSP #7, was not asked screening questions and no temperature check was performed by the facility staff. At 5:50am, DSP #2 and DSP #7 indicated they had been trained on Covid-19 requirements which included to screen visitors by asking screening questions, complete temperature checks, and to ensure visitors wore a face mask before visiting inside the group home. On 7/13/2022 at 1:40pm, a review was conducted of the facility's 8/2021 "Infection Control" and 5/27/2020 "Infection Control and Prevention During Pandemic Covid-19" policies which indicated "Bona Vista Hand Washing Policy and Procedure...Staff and Consumers hands should be washed at the following times...Before and after preparing meals, snacks, eating, or giving first aid...After being outside and coming into home...." The policies indicated "all staff must" wear a face mask while working in the group home and visitors would be asked screening questions, temperatures taken, and staff were to ensure face coverings were worn before entry into the group home. On 7/14/2022 at 10:00am, a review of the 2004 "Living in the Community" Medication Administration training manual page 3 indicated "Universal precautions" included washing hands before eating food and to prevent the spread of			

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	infections. On 7/14/2022 at 9:15am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated clients #1, #2, #3, #5, #6, and #7 should wash their hands before eating, after eating, and frequently during the day to prevent the spread of infection. The QIDP indicated the facility followed Universal Precautions to prevent the spread of infection. The QIDP indicated clients should be taught and encouraged to wash their hands before preparing meals, before eating/drinking, and between handling items the clients share to prevent the spread of germs. The QIDP indicated visitors should be screened by asking Covid-19 screening questions, temperature checks completed, and to ensure everyone who visits or works in the group home wore a face mask. The QIDP indicated the facility staff did not implement the facility's Covid-19 plan when these steps were not followed. On 7/14/2022 at 6:00pm, an interview was conducted with the LPN (Licensed Practical Nurse). The LPN indicated clients #1, #2, #3, #5, #6, and #7 should wash their hands before eating, after eating, and frequently during the day to prevent the spread of infection. The LPN indicated the facility followed Universal Precautions to prevent the spread of infection. The LPN indicated clients should be taught and encouraged to wash their hands before preparing meals, before eating/drinking, and between handling items the clients share to prevent the spread of germs. The LPN indicated visitors should be screened by asking Covid-19 screening questions, temperature checks completed, and to ensure everyone who visits inside the group home wore a face mask. The LPN stated,			

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	"Everyone who works in the group home should wear a face mask." The LPN indicated the facility staff did not implement the facility's Covid-19 plan when these steps were not followed. On 7/12/2022 at 11:30am and on 7/13/2022 at 11:40am, a review of the facility's personnel records and Covid-19 vaccination status was conducted. The review indicated DSP #2 and DSP #7 were not vaccinated for Covid-19 and had received trained regarding Covid-19 on 2/18/2022 to wear a face mask while working inside the group home. 9-3-7(a)			
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview, and record review, for 3 of 3 sampled clients (#1, #2, and #3) and 3 additional clients (clients #5, #6, and #7), the facility failed to ensure clients #1, #2, #3, #5, #6, and #7 received the recommended planned menu items for their meals and snacks. Findings include: During the observation periods at the group home, on 7/11/2022 from 2:55pm until 5:55pm and on 7/12/2022 from 5:50am until 7:55am, clients #1, #2, #3, #5, #6, and #7's planned menu for meals and snacks was not available. On 7/11/2022 at 3:15pm, clients #2, #3, #5, and #7 indicated to DSP (Direct Support Professional) #8 they wanted their snacks and the clients began going through the refrigerator, cabinets, and storage closet in the kitchen to look for their snack items. DSP #8	W 0460	=”” p=””> To ensure staff are following recommended menus, the following correction plan will be implemented: The Senior Director completed a retraining on the Menus with the staff. The trainings are documented by way of signed records of trainings	08/10/2022

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	stated, "Well let's see." DSP #8 opened the freezer, and began talking out loud to list the items inside the freezer. Clients #2, #3, and #7 indicated they would eat a chicken breast sandwich and french fries. DSP #8 removed the frozen breaded chicken breasts and bag of french fries from the freezer and began to set the oven. DSP #8 baked chicken breasts and french fries in the oven while clients #2, #3, #5, and #7 stood watching and talking to DSP #8 while he cooked. At 4:15pm, DSP #8 indicated the snack food was done, clients #2 and #6 placed a bag of cut up lettuce in a bowl, client #2 set bottles of different sauces on the dining room table, and client #7 made koolaid in a pitcher. At 4:15pm, clients #1, #2, #3, #5, #6, and #7 were served their snack by DSP #8 of a breaded chicken breast sandwich on two slices of bread and french fries. From 4:30pm until 5:00pm, DSP #8 served clients #1, #2, #3, #5, #6, and #7 a second sandwich of a breaded chicken patty and french fries. At 4:45pm, DSP #8 served client #3 a third breaded chicken patty on two slices of bread and a third serving of french fries. During the observation period, clients #1, #2, #3, #5, #6, and #7 talked to one another and to DSP #7 and DSP #8 regarding what they were making for the supper meal. During both observation periods, no planned menu was available for review for meals and snacks. On 7/12/2022 at 5:50am, DSP #7 stated clients #1, #2, #3, #5, #6, and #7 ate their supper meal of Lasagna and garlic bread "about 6:30pm last night." From 6:30am until 7:55am, clients #1, #2, #4, #5, #6, and #7 ate multiple bowls of cereal and slices of toast for breakfast. No menu was available for review. Client #3 refused breakfast and was not provided the breakfast meal. On 7/11/2022 at 4:30pm, an interview was			

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conducted with DSP #8. DSP #8 stated, "We don't have a menu. We fix whatever they (the clients) want to eat. I'm not aware of any menu." DSP #8 indicated he had worked at the group home since 2018.

On 7/13/2022 at 8:00pm, the QAC (Quality Assurance Coordinator) indicated the group home staff should have followed the planned menu for diets, snacks, and meals served to clients #1, #2, #3, #5, #6, and #7. The QAC provided the 7/10/2022 "Week at a Glance menu Week 2." The week 2 menu indicated "Monday. Snack. PM (Evening) 100 Calorie cracker pack. HS (At Bedtime) Fig Newtons and beverage. Supper. Chopped steak with brown gravy, mashed potatoes, mixed vegetables, wheat bread, pudding with topping, skim milk. Tuesday. Breakfast. Juice of choice, hard boiled egg, french toast sticks, skim milk, decaf. coffee, and syrup." The planned menu was signed by the Registered Dietician (RD).

Client #1's record was reviewed on 7/12/2022 at 10:45am and on 7/13/2022 at 1:00pm. Client #1's 6/29/2022 ISP (Individual Support Plan), 1/22/2022 physician's order, and 4/2022 Registered Dietician's review indicated "a regular diet, no extra portions."

Client #2's record was reviewed on 7/12/2022 at 9:45am and on 7/13/2022 at 11:40am. Client #2's 7/6/2022 ISP, 1/22/2022 physician's order, and 4/2022 Registered Dietician's (RD) review indicated "a regular diet, 1800 calories, no second portions." Client #2's ISP, physician's order, and RD review indicated client #2 was a diabetic, and monitored his blood sugars before breakfast.

Client #3's record was reviewed on 7/12/2022 at

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	10:10am and on 7/13/2022 at 12:15pm. Client #3's 6/4/2022 ISP, 1/22/2022 physician's order, and 4/2022 RD review indicated "a regular diet, no second portions." Client #5's record was reviewed on 7/13/2022 at 2:00pm. Client #5's 6/27/2022 ISP, 1/22/2022 physician's order, and 4/2022 RD review indicated "a regular diabetic diet 1800-2200 calorie daily, low concentrated sweets, no added salt. No seconds at meals except non starchy vegetables. High protein evening snack at 8pm. Low fat diet." Client #5's ISP, physician's order, and RD review indicated client #5 was a diabetic and monitored his blood sugar every morning at 8am. On 7/14/2022 at 9:15am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP stated a breaded chicken breast sandwich and french fries for a snack and when clients #1, #2, #3, #5, #6, and #7 were given multiple servings of the sandwich and french fries "does not sound like a snack." The QIDP indicated the facility staff should have followed the planned menu items for snacks and the meals. The QIDP indicated the group home staff did not follow clients #1, #2, #3, #5, #6, and #7's prescribed diets. On 7/14/2022 at 6:00pm, an interview was conducted with the LPN (Licensed Practical Nurse). The LPN indicated the facility staff should have provided clients #1, #2, #3, #5, #6, and #7 with the planned menu items as recommended on the menu. The LPN stated clients #1, #2, #3, #5, #6, and #7 were on prescribed diets and the multiple breaded chicken breast sandwiches and french fries for a snack was "too much food for a snack." The LPN indicated the facility staff failed to follow clients			

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	#1, #2, #3, #5, #6, and #7's prescribed diets. 9-3-8(a)			
W 0477 Bldg. 00	483.480(c)(1)(i) MENUS Menus must be prepared in advance. Based on observation, interview, and record review, for 3 of 3 sampled clients (#1, #2, and #3) and 3 additional clients (clients #5, #6, and #7), the facility failed to ensure the planned menu was available and followed to ensure clients were provided a balanced planned meal and snacks Findings include: During the observation periods at the group home, on 7/11/2022 from 2:55pm until 5:55pm and on 7/12/2022 from 5:50am until 7:55am, clients #1, #2, #3, #5, #6, and #7's planned menu for meals and snacks was not available and clients #1, #2, #3, #5, #6, #7, and #8 were not provided the planned menu and snack items. On 7/11/2022 at 3:15pm, clients #2, #3, #5, and #7 indicated to DSP (Direct Support Professional) #8 they wanted their snack and the clients began going through the refrigerator, cabinets, and storage closet in the kitchen to look for their snack items. DSP #8 stated, "Well let's see." DSP #8 opened the freezer, and began talking out loud to list the items inside the freezer. Clients #2, #3, and #7 indicated they would eat a chicken breast sandwich and french fries. DSP #8 removed the frozen breaded chicken breast and bag of french fries from the freezer and began to set the oven. DSP #8 baked chicken breasts and french fries in the oven while clients #2, #3, #5, and #7 stood watching and talking to DSP #8 while he cooked. At 4:15pm, DSP #8 indicated the snack food was done, clients #2 and #6 placed a bag of cut up lettuce in a bowl,	W 0477	=""> p="">
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The Senior Director completed a retraining on the Menus with the staff. The trainings are documented by way of signed records of trainings.	08/10/2022

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	client #2 set bottles of different sauces on the dining room table, and client #7 made koolaid in a pitcher. At 4:15pm, clients #1, #2, #3, #5, #6, and #7 were served their snack by DSP #8 of a breaded chicken breast sandwich on two slices of bread and french fries. From 4:30pm until 5:00pm, DSP #8 served clients #1, #2, #3, #5, #6, and #7 a second sandwich of a breaded chicken patty and french fries. At 4:45pm, DSP #8 served client #3 a third breaded chicken patty on two slices of bread and a third serving of french fries. During the observation period, clients #1, #2, #3, #5, #6, and #7 talked to one another and to DSP #7 and DSP #8 regarding what they were making for the supper meal. No planned menu was available for review. On 7/12/2022 at 5:50am, DSP #7 stated clients #1, #2, #3, #5, #6, and #7 ate their supper meal of Lasagna and garlic bread "about 6:30pm last night." From 6:30am until 7:55am, clients #1, #2, #4, #6, and #7 ate multiple bowls of cereal and slices of toast for breakfast. Client #5 declined breakfast. No menu was available for review. On 7/11/2022 at 4:30pm, an interview was conducted with DSP #8. DSP #8 stated, "We don't have a menu. We fix whatever they (the clients) want to eat. I'm not aware of any menu." DSP #8 indicated he had worked at the group home since 2018. On 7/13/2022 at 8:00pm, the QAC (Quality Assurance Coordinator) indicated the group home staff should have followed the planned menu for diets, snacks, and meals served to clients #1, #2, #3, #5, #6, and #7. The QAC provided the 7/10/2022 "Week at a Glance menu for Week 2." The week 2 menu indicated "Monday. Snack. PM (Evening) 100 Calorie cracker pack. HS (At			

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	Bedtime) Fig Newtons and beverage. Supper. Chopped steak with brown gravy, mashed potatoes, mixed vegetables, wheat bread, pudding with topping, skim milk. Tuesday. Breakfast. Juice of choice, hard boiled egg, french toast sticks, skim milk, decaf. coffee, and syrup." The planned menu was signed by the Registered Dietician (RD). On 7/14/2022 at 9:15am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the facility staff should have provided clients #1, #2, #3, #5, #6, and #7 with the menu items as recommended. The QIDP indicated he was not aware of where the group home kept the menu and if the group home staff followed the menu. On 7/14/2022 at 6:00pm, an interview was conducted with the LPN (Licensed Practical Nurse). The LPN indicated the facility staff should have provided clients #1, #2, #3, #5, #6, and #7 with the planned menu items as recommended for snacks and the meals. The LPN indicated she was not aware of where the group home kept the menu. The LPN indicated clients #1, #2, #3, #5, #6, and #7 were on prescribed diets and the multiple breaded chicken breast sandwiches and french fries for a snack was too much food for a snack. The LPN indicated the menu should have been posted for the staff and clients to follow. 9-3-8(a)			