### Statement of Deficiencies and Plan of Correction

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#### Bona Vista Programs Inc

**Address:**

1901 W Golden Hills Dr

**City:** Peru

**State:** IN

**Zip Code:** 46970

This visit was for a fundamental annual recertification and state licensure survey.


Provider Number: 15G535

Facility Number: 001049

AIM Number: 100245300

The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.

**Quality Review of this report completed by #15068 on 4/25/18.**

**Finding(s):**

**GOVERNING BODY**

Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and for 4 additional clients (clients #5, #6, #7, and #8), the governing body failed to exercise operating direction over the facility to ensure maintenance and repairs were completed for clients #1, #2, #3, #4, #5, #6, #7, and #8 and to ensure clients #1, #2, #3, and #4 were not charged for services the facility was to provide.

Findings include:

1. During the observation periods on 4/10/18 from 2:25pm until 6:15pm, and on 4/11/18 from 6:00am until 7:35am, clients #1, #2, #3, #4, #5, #6, #7, and #8 were at the group home. During the observation periods, clients #1, #2, #3, #4, #5, #6, #7, and #8 were at the group home. During the observation periods, clients #1, #2, #3, and #4, and for 4 additional clients (clients #5, #6, #7, and #8), the governing body failed to exercise operating direction over the facility to ensure maintenance and repairs were completed for clients #1, #2, #3, #4, #5, #6, #7, and #8 and to ensure clients #1, #2, #3, and #4 were not charged for services the facility was to provide.

**Corrective Action(s):**

To ensure the floor and door is in good repair, the following

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 90 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.
#7, and #8 accessed the bathrooms, living room, kitchen, and laundry areas. During the observation periods, the back bathroom next to the laundry room had the floor tile seam along the edge of the tub with a gap between the tile and the floor over three inches long. The wooden trim on the floor between the toilet and the shower was missing a four inch section of wood which exposed a sharp edge of the wooden trim.

On 4/10/18 at 4:30pm, an interview with the HM (House Manager) was conducted. The HM stated the back bathroom off the laundry room was "missing the wooden" baseboard trim and "exposed sharp edges" between the tub and the toilet. The HM stated the bathroom floor tile was "damaged and the seam" of the tile "curled upward about three (3") inches long" and needed to be repaired. The HM indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 used the back bathroom.

During both observation periods, clients #4 and #8's shared bedroom door had a three inch hole in the bottom of the bedroom door. On 4/10/18 at 5:40pm, the HM stated the hole in the door was caused by client #4's behavior when she "became upset and she kicked the door" and the hole was the result.

On 4/10/18 at 4:30pm, on 4/11/18 at 9:50am, and on 4/12/18 at 8:45am, the facility's pending maintenance list and the status for items which needed repair at the group home was requested and none was provided by the HM and QIDP (Qualified Intellectual Disabilities Professional).

On 4/12/18 at 8:45am, an interview was conducted with the HM (House Manager) and QIDP (Qualified Intellectual Disabilities Professional). The HM and QIDP indicated the back bathroom

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<tr>
<th>Corrective Action</th>
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<td>1)</td>
<td>Residential House manager will complete a maintenance request for the bathroom floor and bedroom door to be repaired.</td>
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<td>2)</td>
<td>Bona Vista's Maintenance Department will ensure the floor and door is in good repair at the group home.</td>
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<td>3)</td>
<td>The Director and Assistant Director will receive monthly reports from the maintenance department showing the homes initial requests and when services have been completed for administrative oversight.</td>
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<td>4)</td>
<td>The Residential House Manager will complete weekly safety reports, listing any maintenance requests and/or items that need repaired on the report. The safety report, when completed, is sent to the Purchasing &amp; Safety Coordinator, Director of Maintenance and Safety, Executive Vice President of Community Living, Director of Community Living and Assistant Director of Residential Services for administration oversight.</td>
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Corrective Action(s):
To ensure the clients are reimbursed for the flea treatment charges, the following corrective action will be taken:
1) The Director of Community Living will contact Bona Vista’s Billing Office to issue checks back to each client for their
needed the tile floor repaired and/or replaced. The HM and QIDP both indicated the wooden trim between the toilet and the tub was missing. The HM indicated clients #4 and #8’s bedroom door was damaged and needed to be repaired.

On 4/12/18 at 8:45am, an interview was conducted with the Assistant Director of Community Living (ADCL) and the Director of Community Living (DCL). The ADCL and the DCL indicated they were not aware of the repairs needed at the group home. The DCL indicated the back bathroom floor and wooden trim needed to be repaired for clients #1, #2, #3, #4, #5, #6, #7, and #8 to use the bathroom. The DCL indicated she was unsure of the status of clients #4 and #8’s shared bedroom door to be repaired.

2. On 4/10/18 at 3:00pm, clients #1, #2, #3, and #4’s financial records were reviewed at the group home and indicated the following charges to their personal funds from 1/1/18 through 4/10/18:

Client #1 had an expense on 1/4/18 "Purchase Requisition: Order Date: 12/8/17. Purchased from Family Farm and home: $42.79 misc. (miscellaneous) Pet Supplies (receipt). Total: $42.79 (total). (A hand written note initialed by the House Manager (HM) at the bottom indicated) $5.34 each consumer owes." Client #1's financial record indicated $5.34 was charged to her personal funds account for the flea treatment.

Client #2 had an expense on 1/4/18 "Purchase Requisition: Order Date: 12/8/17. Purchased from Family Farm and home: $42.79 misc. (miscellaneous) Pet Supplies (receipt). Total: $42.79 (total). (A hand written note initialed by the House Manager (HM) at the bottom indicated) $5.34 each consumer owes." Client #2's financial record indicated $5.34 was charged to her personal funds account for the flea treatment.
Client #3 had an expense on 1/4/18 "Purchase Requisition: Order Date: 12/8/17. Purchased from Family Farm and home: $42.79 misc. (miscellaneous) Pet Supplies (receipt). Total: $42.79 (total). (A hand written note initialed by the House Manager (HM) at the bottom indicated) $5.34 each consumer owes." Client #3's financial record indicated $5.34 was charged to her personal funds account for the flea treatment.

Client #4 had an expense on 1/4/18 "Purchase Requisition: Order Date: 12/8/17. Purchased from Family Farm and home: $42.79 misc. (miscellaneous) Pet Supplies (receipt). Total: $42.79 (total). (A hand written note initialed by the House Manager (HM) at the bottom indicated) $5.34 each consumer owes." Client #4's financial record indicated $5.34 was charged to her personal funds account for the flea treatment.

On 4/10/18 at 3:23pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the HM (House Manager). The QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 should not be charged for services the facility was to provide. The QIDP indicated she was unsure regarding the pet supplies. The QIDP indicated the two facility cats belonged to the group home and all the clients. The HM stated "All eight clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) should not have been charged for services the facility was to have provided." The HM stated clients #1, #2, #3, #4, #5, #6, #7, and #8 were charged "$5.34 for the flea treatment supplies" for the two facility animals. The HM stated the animals had been at the facility for "years" and the agency paid for the "food, kitty
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- **Findings**:
  - On 4/12/18 at 8:45am, an interview was conducted with the Assistant Director of Community Living (ADCL) and the Director of Community Living (DCL). The ADCL and the DCL indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 should not have been charged for the flea treatment for the two animals at the facility. The ADCL and the DCL both indicated the clients would need to be reimbursed for the flea treatment charges that the facility was to provide.

- **Corrective Action(s)**:
  - W 0125
  - **Completion Date**: 05/18/2018

- **Finding(s)**:
  - a) "Based on observation, record review and interview, for 1 for 4 sampled clients (client #2), the facility failed to ensure client #2 had a legally sanctioned representative to assist her with medical and financial needs.”

- **Corrective Action(s)**:
  - W 0125

- **Findings include**:
  - During the observation periods on 4/10/18 from 2:25pm until 6:15pm, and on 4/11/18 from 6:00am until 7:35am, client #2 was at the group home.
During both observation periods client #2 was prompted by the staff to use the bathroom, complete tasks in the dining room, complete medication administration, assist staff to cook in the kitchen, and eat at the dining room table. On 4/10/18 at 5:50pm, client #2 indicated she did not manage her own money and needed assistance with her medications. Client #2 stated she did not understand money and medications and "staff help me" to understand.

Client #2's record was reviewed on 4/12/18 at 10:55am. Client #2's 6/22/17 ISP (Individual Support Plan) and 6/2017 Risk Assessment indicated client #2 "is emancipated at this time." Client #2's ISP indicated client #2 required staff assistance to initiate and complete daily living skills; needed assistance to complete and follow step by step instructions; "Staff assist [client #2] in managing her finances in the group home." Client #2 did not recognize dangers in the group home or community; was not independent with her medication administration; and did not recognize abuse, neglect, and/or mistreatment. Client #2's record indicated she needed assistance of staff to help with financial and medical decisions.

-Client #2's ISP, Risk Assessment, and 6/2017 BSP (Behavior Support Plan) indicated client #2 was not independent with her finances and/or medical care. Client #2's Risk Assessment, ISP, and BSP indicated client #2 had been the victim of a sexual assault in the past eighteen months while in the community on a leave of absence from the group home. Client #2's Risk Assessment, ISP, and BSP indicated the following areas were reviewed: personal finances, housing, personal safety, medical, behavioral, and civil rights. The assessments, ISP, and BSP indicated client #2

To ensure client #2 has a legally sanctioned representative, the following corrective action will be implemented:

1) The IDT team will meet with client #1 and discuss a legally sanctioned representative for client #1.
2) IDT notes will be reviewed by the Assistant Director and Director. The Assistant Director and Director will actively and continuously seek for client 2 to have a legally sanctioned representative. The Assistant Director and Director will meet quarterly to review the client's legally sanctioned representatives and document any changes.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### IDENTIFICATION NUMBER
15G535

#### BUILDING
00

#### WING

#### DATE SURVEY COMPLETED
04/13/2018

#### NAME OF PROVIDER OR SUPPLIER
BONA VISTA PROGRAMS INC

#### STREET ADDRESS, CITY, STATE, ZIP CODE
1901 W GOLDEN HILLS DR
PERU, IN 46970

#### SUMMARY STATEMENT OF DEFICIENCY

- **ID**: Required twenty-four hour supervision and assistance to understand and to be able to give informed consent in each area. Client #2's record indicated client #2 did not have a current legally sanctioned representative. Client #2's record indicated she was not able to understand to advocate her rights independently. No information was available for review to determine if a guardian had been sought.

- **ID**: On 4/12/18 at 10:55am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional), and the House Manager (HM). The QIDP and the HM both stated client #2's record, Risk Assessment, ISP, and BSP indicated she needed a legally sanctioned representative to assist her with the "decision making process" for medications and with her finances. The QIDP and the HM both indicated client #2 had been the victim of a sexual assault crime in 7/2016 while in the community and client #2 did not recognize danger and dangerous situations. The QIDP indicated client #2 did not have a legally sanctioned representative at this time. The QIDP indicated client #2 had been referred for a guardian and no guardian had been identified at this time.

- **ID**: On 4/13/18 at 10:25am, an interview with the Registered Nurse (RN) was conducted. The RN stated client #2's record, Risk Assessment, ISP, and BSP indicated she needed a legally sanctioned representative to assist her with the "decision making process" for medications and with her finances. The RN stated client #2 had been the victim of a sexual assault in 7/2016 and client #2 did not recognize danger and dangerous situations. The RN indicated client #2 did not have a legally sanctioned representative at this time. The RN indicated client #2 had been referred
W 0323
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for a guardian and no guardian had been identified at this time.

9-3-2(a)

483.460(a)(3)(i)

PHYSICIAN SERVICES

The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.

Based on record review and interview for 2 of 4 sampled clients (clients #2 and #3), the facility failed to annually complete client #2's hearing evaluation and client #3's visual evaluation.

Findings include:

Client #2's record was reviewed on 4/12/18 at 10:55am. Client #2's current audiologist (hearing) examination was completed 1/7/2015. No hearing examination after 1/7/2015 was available for review.

Client #3's record was reviewed on 4/12/18 at 12:30pm. Client #3's current visual examination was completed on 1/26/16 and recommended prescribed eye glasses. Client #3's 6/22/17 ISP (Individual Support Plan) indicated client #3 wore prescribed eye glasses. No visual examination after 1/26/16 was available for review.

On 4/12/18 at 1:35pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the HM (House Manager). The QIDP and the HM indicated client #2's hearing evaluation was last completed 1/7/15 and should have been completed every three years. The QIDP and the HM both indicated client #2 should have been evaluated by the audiologist and was

Finding(s):

a) “Based on record review and interview for 2 of 4 sampled clients (clients #2 and #3), the facility failed to annually complete client #2’s hearing evaluation and client #3’s visual evaluation.”

Corrective Action(s):

To ensure client #2 and client #3 receives their evaluations, the following corrective action will be implemented:

1) The Residential Nurse will schedule client #2’s hearing evaluation and client #3’s vision evaluation.

2) The Residential Nurse and/or House Manager will take each client to their hearing and vision evaluations. These appointments will be documented in the nurses’ notes.

3) Period Service Review (PSR) will be completed on a quarterly basis to ensure all clients are up to date on all the required appointments needed for
not. The QIDP and the HM both stated client #3's vision evaluation was "overlooked" and had been scheduled to be completed. The HM indicated client #3 should have been evaluated for his continued visual needs every two years.

On 4/13/18 at 10:25am, an interview was conducted with the RN (Registered Nurse). The RN indicated client #2's hearing evaluation was last completed 1/7/15 and should have been completed every three years. The RN indicated client #2's hearing evaluation was not current. The RN stated client #3's vision evaluation was "overlooked" and had been scheduled to be completed. The RN indicated client #3 should have been evaluated for his continued visual needs every two years. The RN indicated client #3 wore prescribed eye glasses to see.

9-3-6(a)

483.460(k)(2) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

Based on observation, record review, and interview, for 1 of 5 medications administered (for client #2) during the evening medication administration, the facility failed to administer medication without error for client #2.

Findings include:

On 4/10/18 at 4:30pm, GHS (Group Home Staff) #3 selected client #2's "Metformin 1000mg (milligrams), take 1 tablet by mouth twice a day with meals" for Diabetes Mellitus. At 4:33pm, GHS #3 dispensed the medication in a medication
cups and client #2 took the oral medication. No food was provided during the medication administration. From 4:33pm until 6:07pm, client #2 was not observed to eat food and drink. At 6:07pm, client #2 began to eat her supper meal. At 6:07pm, client #2 indicated her supper was the first bite of food since her lunch meal.

On 4/12/18 at 10:55am, client #2's 4/2018 MAR (Medication Administration Record) and 3/26/18 "Physician's Order" both indicated "Metformin 1000mg (milligrams), take 1 tablet by mouth twice a day with meals" for Diabetes Mellitus.

On 4/12/18 at 8:45am, an interview was conducted with the Director of Community Living (DCL) and Assistant Director of Community Living (ADCL). The DCL and ADCL both indicated client #2's medications should have been administered according to physician's orders. The ADCL indicated the facility followed Core A/Core B Medication Administration Training. The ADCL indicated client #2 should have eaten food within one hour of the medication administration of client #2's Metformin medication.

On 4/13/18 at 10:25am, an interview was conducted with the Registered Nurse (RN). The RN indicated staff should ensure client #2's physician's orders were followed to administer client #2's medication with a meal. The RN indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration. The RN indicated staff did not follow physician's orders when client #2 was not administered her Metformin medication within one hour of eating food and/or a meal.

On 4/12/18 at 8:45am, a review was conducted of
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**Finding(s):**

a) “Based on observation, record review and interview the facility failed to keep medications locked and secure when not administered to all clients in the home.”

**Corrective Action(s):**

To help ensure medications are properly stored and locked, the following corrective action will be implemented:

1) The Residential Nurse will retrain all staff in the home on Bona Vista’s Medication Administration Policy; putting emphasis on properly storing and...
reflux) and Ibuprofen 400mg, take 1 tablet with Omeprazole twice daily (for pain)." GHS #4 opened the capsule and placed the tablet into a pill crusher, crushed the pills, placed the crushed medication on top of the desk, and left the medication room to retrieve a container of applesauce from the kitchen. At 6:25am, GHS #4 left client #3's crushed medication unlocked on top of the desk. At 6:26am, GHS #4 returned to the medication room and administered client #3's crushed medications. At 6:26am, GHS #4 indicated the facility followed Core A/Core B medication administration training and indicated client #3's medications left on top of the desk were left unlocked.

On 4/12/18 at 10:55am, an interview was conducted with the House Manager (HM). The HM indicated medications should be kept locked when not being administered. The HM indicated when GHS #4 left the medication room she should have locked client #3's medications.

On 4/13/18 at 10:25am, an interview was conducted with the agency RN (Registered Nurse). The RN indicated medications should be kept locked when not being administered. The RN indicated client #3's crushed medications should have been locked inside the medication cabinet when staff were not within eye sight of the medications. The RN indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 had access to client #3's crushed medication left on top of the desk. The RN indicated the facility followed "Living in the Community" for medication administration and security.

On 4/12/18 at 8:45am, a review of the facility's 2004 "Living in the Community" Core A/Core B training for medication administration indicated in "Core
Lesson 3: Principles of Administering Medication** medication should be kept locked when not administered and in direct eye sight of the facility staff.

9-3-6(a)

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, record review, and interview, for 1 of 1 sampled client who received a modified diet (client #3), the facility failed to ensure client #3 received his prescribed modified diet.

Findings include:

During the observation period, on 4/10/18 from 2:25pm until 6:15pm, client #3 was observed at the group home. From 5:50pm until 6:07pm, the HM (House Manager) and GHS (Group Home Staff) #3 assisted clients at the dining room table to serve their foods. From 5:50pm until 6:07pm, GHS #3 assisted client #3 to serve himself a regular consistency diet of whole slice of toasted garlic bread and a slice of baked fish on his plate. From 5:50pm until 6:07pm, client #3 picked up his slice of toasted garlic bread and began to chew on the edges of the crust. At 6:07pm, the HM took client #3's toasted garlic bread from his hand, placed the bread on client #3's plate, and stated "[Client #3's] on a pureed diet." At 6:07pm, GHS #3 asked client #3 to help puree his food of a slice of toasted garlic bread, baked fish, Asparagus, Rice with cheese, and Broccoli together in the same container. Client #3 was served by GHS #3 his blended food. At 6:15pm, when asked if he was
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**
15G535

**DATE SURVEY COMPLETED**
04/13/2018

**NAME OF PROVIDER OR SUPPLIER**
BONA VISTA PROGRAMS INC

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1901 W GOLDEN HILLS DR
PERU, IN 46970

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<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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**Summary Statement of Deficiency**

- on a pureed diet, client #6 smiled then laughed and shook his head yes. At 6:15pm, the HM indicated client #6 was at risk to choke and needed a pureed diet.

- During the observation period, on 4/11/18 at 7:00am, GHS #3 asked client #3 to scoop his food with hand over hand staff assistance to combine his foods of a slice of toast and a scrambled egg into the food processor and pureed the food items. At 7:00am, GHS #3 indicated she was taught to puree client #3's food together as one item and indicated no pureed recipe was available for review.

- Client #3's record was reviewed on 4/12/18 at 12:30pm. Client #3's 6/22/17 ISP (Individual Support Plan) indicated client #3 was on a pureed diet because he was at risk to choke. Client #3's 3/26/18 physician's order and 2/9/18 Registered Dietician's (RD) review both indicated client #3 was prescribed a pureed diet because he was at risk to choke.

- On 4/12/18 at 1:35pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the HM. The QIDP and HM indicated client #3 was at risk to choke and needed a pureed diet. The HM indicated no recipe was available for review regarding how staff were to prepare and puree client #3's food.

- On 4/13/18 at 10:25am, an interview was conducted with the RN (Registered Nurse). The RN indicated client #3 was at risk to choke and needed a pureed diet. The RN indicated no recipe was available for review regarding how staff were puree client #3's food. The RN indicated staff should have pureed each item separately and should not have blended the items together.

**Modified Diets**

- modified diets are being followed.

- Any issues or concerns with the modified diet the Residential Nurse will be contacted.
STATE FINDINGS:

The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met.

460 IAC 9-3-3 Facility Staffing

(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.

THIS STATE RULE WAS NOT MET AS EVIDENCED BY:

Based on record review and interview for 2 of 3 personnel records reviewed (Group Home Staff (GHS) #3 and GHS #9), the facility failed to obtain a yearly PPD and/or chest x-ray for GHS #3 and GHS #9.

Finding(s):

Finding(s):

a) “Based on record review and interview for 2 of 3 personnel records reviewed, the facility failed to obtain a yearly PPD and/or chest x-ray for GHS #3 and GHS #9.

Corrective Action(s):

To help ensure all staff obtain their yearly PPD and/or chest x-ray, the following corrective action(s) will be implemented:

1) The Residential House Manager will schedule GHS #3 and GHS #9 a PPD with the agency nurse at the Laguna location.

2) The Assistant Director and/or Director of Community Living will have the agency nurse send us any staff that are out of compliance with their PPD.

3) The Assistant Director and/or Director of Community Living will work with each House Manager to ensure all their staff are in compliance of PPD.
On 4/12/18 at 9:35am, the facility staff personnel records were reviewed and indicated the following:

- GHS #3 was hired on 5/21/17. GHS #3's record indicated a 2/16/17 Mantoux test and did not indicate a current Mantoux skin test available for review to ensure GHS #3 was free of communicable disease.

- GHS #9 was hired on 1/29/18. GHS #9's record did not indicate a completed Mantoux test available for review to ensure GHS #9 was free of communicable disease.

On 4/12/18 at 9:25am, an interview with the ADCL (Assistant Director of Community Living) was conducted. The ADCL indicated she would attempt to locate the current Mantoux testing for GHS #3 and GHS #9. The ADCL indicated GHS #3 and GHS #9 should have had a current Mantoux skin test to ensure they were free of communicable disease and no further information was available for review.

On 4/13/18 at 10:25am, an interview with the agency Registered Nurse (RN) was conducted. The RN indicated she would attempt to locate the current Mantoux testing for GHS #3 and GHS #9. The RN indicated GHS #3 and GHS #9 should have had a current Mantoux skin test to ensure they were free of communicable disease and no further information was available for review.

On 4/13/18 at 2:30pm, an interview with the DCL (Director of Community Living) and the ADCL (Assistant Director of Community Living) was conducted. The ADCL indicated GHS #3 and GHS #9 should have had a current Mantoux skin test to ensure they were free of communicable disease.
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFIX</td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>PREFIX</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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<td>TAG</td>
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</tbody>
</table>

- disease and no further information was available for review.
- 9-3-3(e)