

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/01/2013
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NAME OF PROVIDER OR SUPPLIER CORVILLA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 18443 BULLA RD SOUTH BEND, IN 46637
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W000000	<p>This visit was for an extended annual recertification and state licensure survey. This visit included the investigation of complaint #IN00132940.</p> <p>Complaint #IN00132940: SUBSTANTIATED, Federal and State deficiencies related to the allegation are cited at W122, W125, W149, W157, W186, and W227.</p> <p>Dates of Survey: July 22, 23, 24, 25, 26, 29, 31, and August 1, 2013</p> <p>Facility Number: 000740 Provider Number: 15G214 AIM Number: 100234800</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/7/13 by Ruth Shackelford, QIDP.</p>	W000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (clients A, B, C, and D) and 4 additional clients (clients E, F, G, and H). The facility failed to implement their policy and procedures to prevent neglect in regard to staff supervision of client C which resulted in client C's escalating behaviors of physical threats towards clients A, B, D, E, F, G, and H and client C's behaviors of eating glass and AWOL (Absent Without Leave).</p> <p>Findings include:</p> <p>Please refer to W149. The facility neglected to implement the facility's policy and procedure to protect clients A, B, D, E, F, G, and H from client C's threats of physical aggression, neglected to supervise client C according to her documented identified behavioral needs, and neglected to implement effective corrective action after continued incidents and threats of harm for 8 of 8 clients (clients A, B, C, D, E, F, G, and H).</p> <p>Please refer to W125. The facility failed to ensure client C had a legally sanctioned</p>	W000122	To ensure clients A,B, D, E,F,G and H are protected from client C's behavior of physical aggression and that client C is protected from harming herself by eating inedible objects and being AWOL, the facility has increased its staff. Client C behavior plan has also revised and a Risk Management Plan for PICA has been implemented by the QIDP. The QDIP will be responsible for monitoring the home on a weekly basis to access the safety of the environment. The QIDP will also review client C's Behavior Plan and Risk Management Plan quarterly to ensure Client C's needs are being addressed. The QIDP has monitored the facilities other homes to determine if a deficiency of this nature is occurring in any of them and none were found.	08/07/2013	

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	<p>guardian to assist her with her medical and financial needs per her assessments for 1 of 4 sampled clients (client C).</p> <p>Please refer to W157. The facility failed to take effective corrective action to prevent client C's behaviors of AWOL (Absence Without Leave), PICA (eating inedibles), and physical aggression for 6 of 11 BDDS (Bureau of Developmental Disabilities Services) reports reviewed from 7/2012 through 7/2013.</p> <p>This federal tag relates to complaint #IN00132940.</p> <p>9-3-2(a)</p>			

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W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client C) to ensure client C had a legally sanctioned guardian to assist her with her medical and financial needs per her assessments.</p> <p>Findings include:</p> <p>On 7/24/13 at 12:20pm, a record review for client C was conducted. Client C's 7/13/13 Comprehensive Functional Assessment (CFA) summary indicated "The following areas were reviewed: personal finances, housing, personal safety, medical, human awareness, behavioral/social, civil rights, and communication. The assessment(s) revealed [client C] requires assistance to give informed consent in each area. [Client C] does not have a guardian."</p> <p>On 7/26/13 at 8:10am, an interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted. The QIDP indicated client C's CFA did indicate she needed a guardian to assist</p>	W000125	The QIDP is in the process of finding a guardian for Client C. Her mother has been spoken to and she is willing to seriously consider seeking legal guardianship of her. All client records have been reviewed and it has found that each resident that requires assistance to give informed consent regarding medical needs, civil rights and financial management have a guardian to assist them. To ensure that each resident's rights are met the QIDP will be responsible for monitoring Corvilla's Informed Consent assessment annually and implementing its findings. This procedure will be effective immediately.	08/27/2013			

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	<p>her with her medications and with her finances. The QIDP indicated client C had an advocate at this time that did not meet client C's identified guardianship needs. The QIDP indicated client C did not understand her rights, medications, or money.</p> <p>This federal tag relates to complaint #IN00132940.</p> <p>9-3-2(a)</p>			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 8 of 8 clients (clients A, B, C, D, E, F, G, and H), the facility neglected to implement the facility's policy and procedure to protect clients A, B, D, E, F, G, and H from client C's threats of physical aggression, neglected to supervise client C according to her documented identified behavioral needs, and neglected to implement effective corrective action after continued incidents and threats of harm.</p> <p>Findings include:</p> <p>On 7/22/13 at 11:45am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 07/01/12 through 07/22/13. The review indicated the following:</p> <p>-A 7/17/13 BDDS report for an incident on 7/16/13 at 11:00pm, indicated client C was taken to the local hospital ER (Emergency Room) "because she swallowed a small piece of glass." The report indicated "Once at the hospital the scan was ran (sic) and it was discovered that [client C] had also swallowed other</p>	W000149	To ensure that the facility does not fail to adhere and to implement appropriately its Abuse and Neglect Policy in the future appropriate corporate staff have been re-trained on the policy. This re-training will ensure that a deficiency of the nature does not occur in the future. Also, to ensure that a deficiency of this nature does not occur again; the OIDP will be responsible for monitoring the home on a weekly basis to determine if sufficient staff is in place to maintain a safe environment for all residents. The QIDP will also be responsible for ensuring all Behavior and Risk Management Plans that aid in maintaining a safe environment are implemented appropriately.	08/27/2013			

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	<p>items too." The report indicated "one item appeared to have a jagged edge and the doctor wanted to observe [client C] overnight...." The report indicated client C had left the home AWOL (Absent Without Leave) "in the morning" during the overnight period, the one facility staff was following client C down Bulla Ave., and the staff had called the QIDP (Qualified Intellectual Disabilities Professional). The report indicated the QIDP came to the home, client C was back in bed, and the group home manager was sitting in client C's doorway. The report indicated client C remained at the group home and did not attend day services on 7/16/13, client C was "peaceful all day," and when the next shift of personnel came in at 2:30pm, client C became "agitated." Client C wanted to make phone calls, was yelling and screaming, and "within 10 (ten) minutes [client C] broke a lava lamp bend (sic) over picked up a small piece of glass and swallowed it." Client C was taken to the local hospital ER. Client C "became combative and needed to be restrained four times. She attempt (sic) to hit, kick, and choke hospital personnel." Client C was admitted for observation for the glass and other unidentified objects and then was transferred the following day to the behavioral unit at the hospital. The report indicated "Plan to resolve: [client C] has</p>				

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	<p>become increasingly hard to manage. She is a threat to herself as well as to others. We are currently working with our local BDDS office to determine the best possible living environment for [client C]."</p> <p>-A 6/18/13 BDDS report for an incident on 6/17/13 at 5:30pm, indicated "On Sunday 6/16/13 the people who transport [client C] and other housemates to church did not show up." The report indicated client C "became very upset and agitated." The house staff attempted to call the church transport people without success, client C called her friend to come and transport her, her friend was gone so client C spoke with the friend's wife. After the wife "refused (client C's request), [client C] cursed her, and later client C apologized to the wife." Client C continued to be agitated, call the wife back, and screamed at the wife again. Client C continued to call screaming at the wife until the friend came to the group home to see client C later in the day. The report indicated "While coming from the day program on Monday 6/17/13, [client C] began asking...to see her friend on Friday." The driver of the van did not respond, client C asked again, and the driver told client C that this was not the time to discuss that. Once the van stopped at the group home, client C</p>				

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	<p>"jumped off the van and ran into the house," ran into her bedroom, picked up an item and "appeared to be trying to cut her wrist." The staff person took the item away from client C, client C "began choking" the staff, and hitting staff. Client C then left the group home AWOL. Staff followed client C and with the police department assistance returned client C to the group home. Client C was transported to the inpatient behavioral hospital. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 6/26/13 Follow up BDDS report to the 6/17/13 incident indicated "On 6/18/13 [client C] was admitted to inpatient hospital for eight (8) days, discharged on 6/24/13 from the hospital to the group home." The report indicated the agency had hired a "permanent one on one staff for [client C]" and increased the staff hours on the evening shift.</p> <p>-A 5/21/13 BDDS report for an incident on 5/20/13 at 4:15pm, indicated "On Sunday 5/19/13 [client C] became very upset, difficult to handle and aggressive towards both staff and residents because a friend's daughter would not call [client C] or provide a phone number." The report indicated on 5/21/13 when client C was</p>				

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	<p>picked up from day services client C "was worked up again." The report indicated "during transport" home, client C was upset over not having the phone number, began to scream, yell, and began to choke the staff driving the van. The staff pulled off the road into a church parking lot where other agency staff were, and the nurse calmed client C then rode to the group home on the van with clients A, B, C, D, E, F, G, and H. Once the van stopped at the group home client C "jumped off and ran" from the van and the group home. One staff followed client C and the other staff called police. Client C returned to the group home with staff, began to scream, yell, and punched a picture with her fist. Client C "grabbed the glass, and was holding it tightly in her hand. The glass bit into [client C's] palms and [client C] began bleeding." The report indicated client C was taken to the behavioral hospital for admission. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 5/6/13 BDDS report for an incident on 5/5/13 at 2:30pm, indicated client C went out on an outing with her friend. The friend and client C called his daughter who was not at home, and client C was told by the friend she could call again on a different outing. On Sunday client C</p>						

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	<p>talked "all day about not being able to talk to [friend's daughter]...[client C] became so worked up that the staff called the nurse to see if they could administer a PRN (as needed behavioral medication) to [client C]. The nurse said yes, however before the med could be given the [staff] on duty heard a crash in [client C's] room." When the staff entered the room they "saw [client C] cutting her self with the glass from a picture frame," staff immediately removed the glass, and client C was transported to the inpatient behavioral hospital. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 5/10/13 follow up BDDS report to the 5/5/13 incident indicated client C was returned to the facility on 5/7/13. The report indicated "two new persons were hired to act as one on one staff for [client C]."</p> <p>-A 4/11/13 BDDS report for an incident on 4/10/13 at 3:00pm, indicated "On Saturday 4/6/13 [client C] had a behavioral outburst. So following her behavior plan she lost an activity. [Client C] began obsessing over this lost activity Monday evening causing a lot of confusion in the house. By Tuesday early evening she was so upset she began</p>						

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	<p>attempting to leave the house. When she was unable to leave, she called the police five (5) times. After the fifth call they called the house and informed the manager that they needed to come to the house and see what was going on." The report indicated "when the QMRP (Qualified Mental Retardation Professional) reached the home she witnessed two police officers escorting [client C] back into the home. Once in the house [client C] started hollering, screaming, and crying about the lost activity again. The police asked her to stop being loud and sit down. She began threatening the staff, the QMRP, all of a sudden [client C] got up and hit the policeman in the face with her fist. The policeman took her down, and decided to escort her to the local mental health hospital." The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 4/10/13 BDDS report for an incident on 4/10/13 at 9:00am, indicated client C was "dropped off along with other members of her group home, by the staff at the workshop. [Client C] came in and walked directly into the cafeteria and over to the vending machines to purchase a pop." Workshop staff greeted her, client C stated "I'm leaving," and left the</p>			

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	<p>cafeteria. Client C walked for a few minutes and was seen heading for the exit door of the workshop. Client C exited the building, was followed by workshop staff, prompted to return to the workshop, and began to verbally threaten staff. Client C attempted to leave AWOL again from the workshop, was followed by staff, returned to workshop, and the residential provider was contacted to pick up client C. When the residential provider came to pick up the client, police were contacted to assist with transporting the client to the inpatient unit at the behavioral hospital. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>On 7/24/13 from 5:35pm until 7:10pm, Group Home Staff (GHS) #1, GHS #2, and Clients A, B, C, D, E, F, G, and H were at the group home. From 5:35pm until 6:02pm, clients A, B, C, D, E, F, G, and H were at the group home with two (2) staff (GHS #1 and GHS #2). At 6:02pm, GHS #1 left the group home with clients D and G to go grocery shopping. Clients A, B, C, E, F, and H were at the group home with one staff, GHS #2. From 6:02pm until 7:10pm, one (1) staff and six (6) clients, including client C, were at the group home and no one on one supervision of client C was provided</p>				

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	<p>during that time. During the observation period client C walked throughout the home into the dining room, up/down the hallway, bathrooms, kitchen, and the front living room with glass pictures, lamps, and decorative items without one on one staff. At 5:35pm, GHS #2 indicated client C had returned to the group home on 7/23/13 from the inpatient behavioral hospital.</p> <p>Confidential Interview #1 indicated she was afraid of client C.</p> <p>Confidential Interview #2 indicated she was afraid of client C because she was physically aggressive and stated "she will hurt me."</p> <p>Confidential Interview #3 stated she "was not afraid of [client C] as long as my staff are here with me."</p> <p>Confidential Interview #4 stated she was afraid client C was going to hurt somebody soon "real bad."</p> <p>Confidential Interview #5 indicated she was afraid of client C.</p> <p>Confidential Interview #6 indicated she worried about client C breaking her stuff and hurting her. CI #6 indicated client C had attempted to hit her before.</p>				

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	<p>Confidential Interview #7 indicated she wished client C would stay away, cause it made her sad when client C tries to hit people.</p> <p>On 7/22/13 at 11am, the facility's undated "Abuse or Neglect of Residents by Agency Staff" Policy/Procedure was reviewed. The policy/procedure indicated "...good judgement must be exercised in those difficult and frustrating situations which may periodically occur in the course of service to an individual...Neglect of a client shall consist of any of the following act: Exposing a client to unnecessary hardship, fatigue, or mental or physical strains that tend to injure the health, physical, or moral well being of that client. Failure to provide proper and sufficient food, clothing, maintenance, and a clean and sanitary physical environment...."</p> <p>On 7/22/13 at 12:15pm, a review was completed of the "Bureau of Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual,</p>				

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	<p>or psychological abuse by anyone including but not limited to facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs...."</p> <p>On 7/26/13 at 8:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated there were not sufficient staff on duty to implement client C's one on one staffing needs. The QIDP indicated the facility had not increased the overnight shift of personnel to include one on one supervision for client C. The QIDP indicated client C had left AWOL during the overnight period in the past. The QIDP indicated client C was to have corrective action of one on one staff after the 5/2013 incident of physical aggression, AWOL, and cutting herself with glass. The QIDP stated "We dropped the ball." Client C should have had one on one supervision while at the group home and stated "she is unpredictable." The QIDP stated clients A, B, D, E, F, G, and H "were at risk from [client C's] behaviors" and stated the agency "continues to try to keep them safe." The QIDP indicated the staff neglected to implement the abuse/neglect policy and procedure.</p>			

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	This federal tag relates to complaint #IN00132940. 9-3-2(a)				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, record review, and interview, for 6 of 11 BDDS (Bureau of Developmental Disabilities Services) reports reviewed from 7/2012 through 7/2013, the facility failed to take effective corrective action to prevent client C's behaviors of AWOL (Absence Without Leave), PICA (eating inedibles), and physical aggression.</p> <p>Findings include:</p> <p>On 7/22/13 at 11:45am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 07/01/12 through 07/22/13. The review indicated the following:</p> <p>-A 7/17/13 BDDS report for an incident on 7/16/13 at 11:00pm, indicated client C was taken to the local hospital ER (Emergency Room) "because she swallowed a small piece of glass." The report indicated "Once at the hospital the scan was ran (sic) and it was discovered that [client C] had also swallowed other items too." The report indicated "one item appeared to have a jagged edge and the doctor wanted to observe [client C] overnight...." The report indicated client</p>	W000157	To ensure that sufficient safety measures to prevent Client C from being AWOL, PICA and physical aggression the following has been put in place:1. One on one staff has been hired to exclusively work with client C for each shift - including the overnight shift.2. ClientC's Behavior Plan has been revised to include PICA (the plan already included physical aggression and AWOL). The plan has been approved by her IDT and the COrvilla HRC. Also, the staff has been re-trained on the program and trained on the revisions.3. Client C's psychiatrist has also seen her. He has reviewed her medications and made some shanges. The HRC has beed advised of the doctor's recommendations and has agreed with them. She will be monitored by her psychiatrist on a as needed bases.To ensure there are no other deficiencies of this nature in the future, the QIDP will be responsible for monitoring the safety of the residents and putting into place any needed corrective action.	08/27/2013	

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	C had left the home AWOL (Absent Without Leave) "in the morning" during the overnight period, the one facility staff was following client C down Bulla Ave., and the staff had called the QIDP (Qualified Intellectual Disabilities Professional). The report indicated the QIDP came to the home, client C was back in bed, and the group home manager was sitting in client C's doorway. The report indicated client C remained at the group home and did not attend day services on 7/16/13, was "peaceful all day," and when the next shift of personnel came in at 2:30pm, client C became "agitated." Client C wanted to make phone calls, yelling, screaming, and "within 10 (ten) minutes [client C] broke a lava lamp bend (sic) over picked up a small piece of glass and swallowed it." Client C was taken to the local hospital ER. Client C "became combative and needed to be restrained four times. She attempt (sic) to hit, kick, and choke hospital personnel." Client C was admitted for observation for the glass and other unidentified objects and then transferred the following day to the behavioral unit at the hospital. The report indicated "Plan to resolve: [client C] has become increasingly hard to manage. She is a threat to herself as well as to others. We are currently working with our local BDDS office to determine the best						

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	<p>possible living environment for [client C]."</p> <p>-A 6/18/13 BDDS report for an incident on 6/17/13 at 5:30pm, indicated "On Sunday 6/16/13 the people who transport [client C] and other housemates to church did not show up." The report indicated client C "became very upset and agitated." The house staff attempted to call the church transport people without success, client C called her friend to come and transport her, and her friend was gone so client C spoke with the friend's wife. After the wife "refused (client C's request), [client C] cursed her," and later client C apologized to the wife. Client C continued to be agitated, call the wife back, and screamed at the wife again. Client C continued to call the wife screaming until the friend came to the group home to see client C later in the day. The report indicated "While coming from the day program on Monday 6/17/13, [client C] began asking...to see her friend on Friday." The driver of the van did not respond, client C asked again, and the driver told client C that this was not the time to discuss that. Once the van stopped at the group home, client C "jumped off the van and ran into the house," ran into her bedroom, picked up an item and "appeared to be trying to cut her wrist." The staff person took the item</p>						

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	<p>away from client C, client C "began choking" the staff, and hitting staff. Client C then left the group home AWOL. Staff followed client C and with the police department assistance returned client C to the group home. Client C was transported to the inpatient behavioral hospital. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 6/26/13 Follow up BDDS report to the 6/17/13 incident indicated "On 6/18/13 [client C] was admitted to inpatient hospital for eight (8) days, discharged on 6/24/13 from the hospital to the group home." The report indicated the agency had hired a "permanent one on one staff for [client C]" and increased the staff hours on the evening shift.</p> <p>-A 5/21/13 BDDS report for an incident on 5/20/13 at 4:15pm, indicated "On Sunday 5/19/13 [client C] became very upset, difficult to handle and aggressive towards both staff and residents because a friend's daughter would not call [client C] or provide a phone number." The report indicated on 5/21/13 when client C was picked up from day services client C "was worked up again." The report indicated "during transport" home, client C was upset over not having the phone number.</p>				

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	<p>Client C began to scream, yell, and began to choke the staff driving the van. The staff pulled off the road into a church parking lot where other agency staff were, and the nurse calmed client C then rode to the group home on the van with clients A, B, C, D, E, F, G, and H. Once the van stopped at the group home client C "jumped off and ran" from the van and the group home. One staff followed client C and the other staff called police. Client C returned to the group home with staff, began to scream and yell, and punched a picture with her fist. Client C grabbed the glass and was holding it tightly in her hand. The "glass bit into [client C's] palms and [client C] began bleeding." The report indicated client C was taken to the behavioral hospital for admission. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 5/6/13 BDDS report for an incident on 5/5/13 at 2:30pm, indicated client C went out on an outing with her friend, the friend and client C called his daughter who was not at home, and client C was told by the friend she could call again on a different outing. On Sunday client C talked "all day about not being able to talk to [friend's daughter]...[client C] became so worked up that the staff called the</p>						

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	<p>nurse to see if they could administer a PRN (as needed behavioral medication) to [client C]. The nurse said yes, however before the med could be given the [staff] on duty heard a crash in [client C's] room." When the staff entered the room they "saw [client C] cutting her self with the glass from a picture frame," staff immediately removed the glass, and client C was transported to the inpatient behavioral hospital. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 5/10/13 follow up BDDS report to the 5/5/13 incident indicated client C was returned to the facility on 5/7/13. The report indicated "two new persons were hired to act as one on one staff for [client C]."</p> <p>-A 4/11/13 BDDS report for an incident on 4/10/13 at 3:00pm, indicated "On Saturday 4/6/13 [client C] had a behavioral outburst. So following her behavior plan she lost an activity. [Client C] began obsessing over this lost activity Monday evening causing a lot of confusion in the house. By Tuesday early evening she was so upset she began attempting to leave the house. When she was unable to leave, she called the police five (5) times. After the fifth call they</p>						

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	<p>called the house and informed the manager that they needed to come to the house and see what was going on." The report indicated "when the QMRP (Qualified Mental Retardation Professional) reached the home she witnessed two police officers escorting [client C] back into the home. Once in the house [client C] started hollering, screaming, and crying about the lost activity again. The police asked her to stop being loud and sit down. She began threatening the staff, the QMRP, all of a sudden [client C] got up and hit the policeman in the face with her fist. The policeman took her down, and decided to escort her to the local mental health hospital." The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 4/10/13 BDDS report for an incident on 4/10/13 at 9:00am, indicated client C was "dropped off along with other members of her group home, by the staff at the workshop. [Client C] came in and walked directly into the cafeteria and over to the vending machines to purchase a pop." Workshop staff greeted her, client C stated "I'm leaving," and left the cafeteria. Client C walked a few minutes and was seen heading for the exit door of the workshop. Client C exited the</p>						

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	<p>building, was followed by workshop staff, prompted to return to the workshop, and began to verbally threaten staff. Client C attempted to leave AWOL again from the workshop, was followed by staff, returned to workshop, and the residential provider was contacted to pick up client C. When the residential provider came to pick up the client C, police were contacted to assist with transporting the client to the inpatient unit at the behavioral hospital. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>On 7/24/13 from 5:35pm until 7:10pm, Group Home Staff (GHS) #1, GHS #2, and Clients A, B, C, D, E, F, G, and H were at the group home. From 5:35pm until 6:02pm, clients A, B, C, D, E, F, G, and H were at the group home with two (2) staff (GHS #1 and GHS #2). At 6:02pm, GHS #1 left the group home with clients D and G to go grocery shopping. Clients A, B, C, E, F, and H were at the group home with one staff, GHS #2. From 6:02pm until 7:10pm, one (1) staff and six (6) clients, including client C, were at the group home and no one on one supervision of client C was provided during that time. During the observation period client C walked throughout the home into the dining room, up/down the</p>				

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	<p>hallway, bathrooms, kitchen, and the front living room with glass pictures, lamps, and decorative items with no one on one staff. At 5:35pm, GHS #2 indicated client C had returned to the group home on 7/23/13 from the inpatient behavioral hospital.</p> <p>On 7/26/13 at 8:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the corrective action the agency had implemented was not sufficient to protect clients A, B, D, E, F, G, and H from client C's continued behaviors. The QIDP indicated the facility had not increased the overnight shift of personnel to include one on one supervision for client C. The QIDP indicated client C had left AWOL during the overnight period in the past. The QIDP indicated client C was to have corrective action of one on one staff after the 5/2013 incident of physical aggression, AWOL, and cutting herself with glass. The QIDP stated "We dropped the ball."</p> <p>This federal tag relates to complaint #IN00132940.</p> <p>9-3-2(a)</p>						

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review, and interview, for 8 of 8 clients (clients A, B, C, D, E, F, G, and H) who lived in the group home, the facility failed to provide enough staff on duty to supervise clients and provide one on one staff for client C based on their identified needs.</p> <p>Findings include:</p> <p>On 7/24/13 from 5:35pm until 7:10pm, Group Home Staff (GHS) #1, GHS #2, and Clients A, B, C, D, E, F, G, and H were at the group home. From 5:35pm until 6:02pm, clients A, B, C, D, E, F, G, and H were at the group home with two (2) staff (GHS #1 and GHS #2). At 6:02pm, GHS #1 left the group home with clients D and G to go grocery shopping. Clients A, B, C, E, F, and H were at the group home with one staff, GHS #2. From 6:02pm until 7:10pm, one (1) staff and six (6) clients, including client C, were at the group home and no one on one supervision of client C was provided</p>	W000186	To ensure the facility provides sufficient direct care staff to manage and supervise the residents in accordance with their Individual Program Plans; the facility added staff to the home to each of its shifts, including the awake overnight shift. The allows for Client C to have a one on one staff person. The QIDP will be responsible for keeping the Executive Director apprised of the situation and making, if needed, recommendations for any changes The QIDP has visited and assessed the other homes to see if a similar deficiency is occurring in them and found no condemns.	08/02/2013	

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	<p>during that time. During the observation period client C walked throughout the home into the dining room, up/down the hallway, bathrooms, kitchen, and the front living room with glass pictures, lamps, and decorative items with no one on one staff. At 5:35pm, GHS #2 indicated client C had returned to the group home on 7/23/13 from the inpatient behavioral hospital.</p> <p>On 7/22/13 at 11:45am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 07/01/12 through 07/22/13. The review indicated the following:</p> <p>-A 7/17/13 BDDS report for an incident on 7/16/13 at 11:00pm, indicated client C was taken to the local hospital ER (Emergency Room) "because she swallowed a small piece of glass." The report indicated "Once at the hospital the scan was ran (sic) and it was discovered that [client C] had also swallowed other items too." The report indicated "one item appeared to have a jagged edge and the doctor wanted to observe [client C] overnight..." The report indicated client C had left the home AWOL (Absent Without Leave) "in the morning" during the overnight period, the one facility staff was following client C down Bulla Ave.,</p>						

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	<p>and the staff had called the QIDP (Qualified Intellectual Disabilities Professional). The report indicated the QIDP came to the home, client C was back in bed, and the group home manager was sitting in client C's doorway. The report indicated client C remained at the group home and did not attend day services on 7/16/13, client C was "peaceful all day," and when the next shift of personnel came in at 2:30pm, client C became "agitated." Client C wanted to make phone calls, was yelling, and screaming, and "within 10 (ten) minutes [client C] broke a lava lamp bend (sic) over picked up a small piece of glass and swallowed it." Client C was taken to the local hospital ER. Client C "became combative and needed to be restrained four times. She attempt (sic) to hit, kick, and choke hospital personnel." Client C was admitted for observation for the glass and other unidentified objects and then was transferred the following day to the behavioral unit at the hospital. The report indicated "Plan to resolve: [client C] has become increasingly hard to manage. She is a threat to herself as well as to others. We are currently working with our local BDDS office to determine the best possible living environment for [client C]."</p> <p>-A 6/18/13 BDDS report for an incident</p>				

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	<p>on 6/17/13 at 5:30pm, indicated "On Sunday 6/16/13 the people who transport [client C] and other housemates to church did not show up." The report indicated client C "became very upset and agitated." The house staff attempted to call the church transport people without success, client C called her friend to come and transport her, and her friend was gone so client C spoke with the friend's wife. After the wife "refused (client C's request), [client C] cursed her, and later client C apologized to the wife." Client C continued to be agitated, call the wife back, and screamed at the wife again. Client C continued to call screaming at the wife until the friend came to the group home to see client C later in the day. The report indicated "While coming from the day program on Monday 6/17/13, [client C] began asking...to see her friend on Friday." The driver of the van did not respond, client C asked again, and the driver told client C that this was not the time to discuss that. Once the van stopped at the group home, client C "jumped off the van and ran into the house," ran into her bedroom, picked up an item and "appeared to be trying to cut her wrist." The staff person took the item away from client C, client C "began choking" the staff, and hitting staff. Client C then left the group home AWOL. Staff followed client C and with the</p>						

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	<p>police department assistance returned client C to the group home. Client C was transported to the inpatient behavioral hospital. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 6/26/13 Follow up BDDS report to the 6/17/13 incident indicated "On 6/18/13 [client C] was admitted to inpatient hospital for eight (8) days, discharged on 6/24/13 from the hospital to the group home." The report indicated the agency had hired a "permanent one on one staff for [client C]" and increased the staff hours on the evening shift.</p> <p>-A 5/21/13 BDDS report for an incident on 5/20/13 at 4:15pm, indicated "On Sunday 5/19/13 [client C] became very upset, difficult to handle and aggressive towards both staff and residents because a friend's daughter would not call [client C] or provide a phone number." The report indicated on 5/21/13 when client C was picked up from day services client C "was worked up again." The report indicated "during transport" home, client C was upset over not having the phone number, began to scream, yell, and began to choke the staff driving the van. The staff pulled off the road into a church parking lot where other agency staff were, and the</p>				

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	<p>nurse calmed client C then rode to the group home on the van with clients A, B, C, D, E, F, G, and H. Once the van stopped at the group home client C "jumped off and ran" from the van and the group home. One staff followed client C and the other staff called police. Client C returned to the group home with staff, began to scream, yell, and punched a picture with her fist. Client C "grabbed the glass, and was holding it tightly in her hand. The glass bit into [client C's] palms and [client C] began bleeding." The report indicated client C was taken to the behavioral hospital for admission. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 5/6/13 BDDS report for an incident on 5/5/13 at 2:30pm, indicated client C went out on an outing with her friend, the friend and client C called his daughter who was not at home, and client C was told by the friend she could call again on a different outing. On Sunday client C talked "all day about not being able to talk to [friend's daughter]...[client C] became so worked up that the staff called the nurse to see if they could administer a PRN (as needed behavioral medication) to [client C]. The nurse said yes, however before the med could be given the [staff] on duty heard a crash in [client C's]</p>						

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	<p>room." When the staff entered the room they "saw [client C] cutting her self with the glass from a picture frame," staff immediately removed the glass, and client C was transported to the inpatient behavioral hospital. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 5/10/13 follow up BDDS report to the 5/5/13 incident indicated client C was returned to the facility on 5/7/13. The report indicated "two new persons were hired to act as one on one staff for [client C]."</p> <p>-A 4/11/13 BDDS report for an incident on 4/10/13 at 3:00pm, indicated "On Saturday 4/6/13 [client C] had a behavioral outburst. So following her behavior plan she lost an activity. [Client C] began obsessing over this lost activity Monday evening causing a lot of confusion in the house. By Tuesday early evening she was so upset she began attempting to leave the house. When she was unable to leave, she called the police five (5) times. After the fifth call they called the house and informed the manager that they needed to come to the house and see what was going on." The report indicated "when the QMRP (Qualified Mental Retardation</p>				

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	<p>Professional) reached the home she witnessed two police officers escorting [client C] back into the home. Once in the house [client C] started hollering, screaming, and crying about the lost activity again. The police asked her to stop being loud and sit down. She began threatening the staff, the QMRP, all of a sudden [client C] got up and hit the policeman in the face with her fist. The policeman took her down, and decided to escort her to the local mental health hospital." The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 4/10/13 BDDS report for an incident on 4/10/13 at 9:00am, indicated client C was "dropped off along with other members of her group home, by the staff at the workshop. [Client C] came in and walked directly into the cafeteria and over to the vending machines to purchase a pop." Workshop staff greeted her, client C stated "I'm leaving," and left the cafeteria. Client C walked for a few minutes and was seen heading for the exit door of the workshop. Client C exited the building, was followed by workshop staff, prompted to return to the workshop, and began to verbally threaten staff. Client C attempted to leave AWOL again from the workshop, was followed by staff, returned</p>			

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	<p>to workshop, and the residential provider was contacted to pick up client C. When the residential provider came to pick up the client C, police were contacted to assist with transporting the client to the inpatient unit at the behavioral hospital. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>On 7/25/13 at 11:10am, and on 7/26/13 at 8:10am, the facility's staff schedule was requested for the group home. The facility's staff schedule for July, 2013 indicated for Mondays through Fridays: one staff person from 6:30am until 3:30pm, one staff person 3pm until 10:30pm, one staff person 2:30pm until 10:30pm, one staff person 10:30pm until 8:30am. The staff schedules indicated for Saturdays and Sundays: one staff person 7am until 3:00pm, one staff person from 9:00am until 9:00pm, one staff person from 11am until 7pm, and one staff person from 9:30pm until 8:30am. The schedule did not include one on one staff supervision for client C.</p> <p>On 7/26/13 at 8:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated there were not sufficient staff on duty to implement</p>						

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	<p>client C's one on one staffing needs. The QIDP indicated the facility had not increased the overnight shift of personnel to include one on one supervision for client C. The QIDP indicated client C had left AWOL during the overnight period in the past. The QIDP indicated client C was to have one on one staff after the 5/2013 incident of physical aggression, AWOL, and cutting herself with glass. The QIDP stated "We dropped the ball." The QIDP stated client C "should have had one on one supervision while at the group home" and stated "she is unpredictable." The QIDP stated clients A, B, D, E, F, G, and H "were at risk from [client C's] behaviors" and stated the agency "continues to try to keep them safe." The QIDP indicated clients A, B, C, D, E, F, G, and H required staff supervision twenty-four hours a day. The QIDP indicated the facility staff schedule had not included the increased staff needs as outlined in the BDDS reports.</p> <p>This federal tag relates to complaint #IN00132940.</p> <p>9-3-3(a)</p>			

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, for 1 of 3 sample clients (client C), the facility failed to have a program in place to address client C's behavior of pica (eating inedible items).</p> <p>Findings include:</p> <p>On 7/22/13 at 11:45am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 07/01/12 through 07/22/13. The review indicated the following:</p> <p>-A 7/17/13 BDDS report for an incident on 7/16/13 at 11:00pm, indicated client C was taken to the local hospital ER (Emergency Room) "because she swallowed a small piece of glass." The report indicated "Once at the hospital the scan was ran (sic) and it was discovered that [client C] had also swallowed other items too." The report indicated "one item appeared to have a jagged edge and the doctor wanted to observe [client C] overnight...." The report indicated client C had left the home AWOL (Absent</p>	W000227	To ensure that a resident's IPP contains specific objectives necessary to meet a client's needs the QIDP will be responsible for reviewing the resident's CFA quarterly. When changes occur the QIDP will be responsible for notifying the IDT and making arrangements to develop and implement any new goals/objectives. To ensure there are no other similar deficiencies, the QDIT has reviewed all resident's CFA and found no concerns. Also, a goal/objective has been developed and Client C and is being implemented to managing this newly identified behavior.	08/30/2013			

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	Without Leave) "in the morning" during the overnight period, the one facility staff was following client C down Bulla Ave., and the staff had called the QIDP (Qualified Intellectual Disabilities Professional). The report indicated the QIDP came to the home, client C was back in bed, and the group home manager was sitting in client C's doorway. The report indicated client C remained at the group home and did not attend day services on 7/16/13, client C was "peaceful all day," and when the next shift of personnel came in at 2:30pm, client C became "agitated." Client C wanted to make phone calls, was yelling, and screaming, and "within 10 (ten) minutes [client C] broke a lava lamp bend (sic) over picked up a small piece of glass and swallowed it." Client C was taken to the local hospital ER. Client C "became combative and needed to be restrained four times. She attempt (sic) to hit, kick, and choke hospital personnel." Client C was admitted for observation for the glass and other unidentified objects and then was transferred the following day to the behavioral unit at the hospital. The report indicated "Plan to resolve: [client C] has become increasingly hard to manage. She is a threat to herself as well as to others. We are currently working with our local BDDS office to determine the best possible living environment for [client				

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	<p>C]."</p> <p>-A 6/18/13 BDDS report for an incident on 6/17/13 at 5:30pm, indicated "On Sunday 6/16/13 the people who transport [client C] and other housemates to church did not show up." The report indicated client C "became very upset and agitated." The house staff attempted to call the church transport people without success, client C called her friend to come and transport her, her friend was gone so client C spoke with the friend's wife. After the wife "refused (client C's request), [client C] cursed her, and later client C apologized to the wife." Client C continued to be agitated, call the wife back, and screamed at the wife again. Client C continued to call screaming at the wife until the friend came to the group home to see client C later in the day. The report indicated "While coming from the day program on Monday 6/17/13, [client C] began asking...to see her friend on Friday." The driver of the van did not respond, client C asked again, and the driver told client C that this was not the time to discuss that. Once the van stopped at the group home, client C "jumped off the van and ran into the house," ran into her bedroom, picked up an item and "appeared to be trying to cut her wrist." The staff person took the item away from client C, client C "began</p>			

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	<p>choking" the staff, and hitting staff. Client C then left the group home AWOL. Staff followed client C and with the police department assistance returned client C to the group home. Client C was transported to the inpatient behavioral hospital. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 6/26/13 Follow up BDDS report to the 6/17/13 incident indicated "On 6/18/13 [client C] was admitted to inpatient hospital for eight (8) days, discharged on 6/24/13 from the hospital to the group home." The report indicated the agency had hired a "permanent one on one staff for [client C]" and increased the staff hours on the evening shift.</p> <p>-A 5/21/13 BDDS report for an incident on 5/20/13 at 4:15pm, indicated "On Sunday 5/19/13 [client C] became very upset, difficult to handle and aggressive towards both staff and residents because a friend's daughter would not call [client C] or provide a phone number." The report indicated on 5/21/13 when client C was picked up from day services client C "was worked up again." The report indicated "during transport" home, client C was upset over not having the phone number, began to scream, yell, and began to choke</p>						

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	<p>the staff driving the van. The staff pulled off the road into a church parking lot where other agency staff were, and the nurse calmed client C then rode to the group home on the van with clients A, B, C, D, E, F, G, and H. Once the van stopped at the group home client C "jumped off and ran" from the van and the group home. One staff followed client C and the other staff called police. Client C returned to the group home with staff, began to scream, yell, and punched a picture with her fist. Client C "grabbed the glass, and was holding it tightly in her hand. The glass bit into [client C's] palms and [client C] began bleeding." The report indicated client C was taken to the behavioral hospital for admission. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 5/6/13 BDDS report for an incident on 5/5/13 at 2:30pm, indicated client C went out on an outing with her friend, the friend and client C called his daughter who was not at home, and client C was told by the friend she could call again on a different outing. On Sunday client C talked "all day about not being able to talk to [friends daughter]...[client C] became so worked up that the staff called the nurse to see if they could administer a PRN (as needed behavioral medication) to</p>			

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	<p>house and see what was going on." The report indicated "when the QMRP (Qualified Mental Retardation Professional) reached the home she witnessed two police officers escorting [client C] back into the home. Once in the house [client C] started hollering, screaming, and crying about the lost activity again. The police asked her to stop being loud and sit down. She began threatening the staff, the QMRP, all of a sudden [client C] got up and hit the policeman in the face with her fist. The policeman took her down, and decided to escort her to the local mental health hospital." The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>-A 4/10/13 BDDS report for an incident on 4/10/13 at 9:00am, indicated client C was "dropped off along with other members of her group home, by the staff at the workshop. [Client C] came in and walked directly into the cafeteria and over to the vending machines to purchase a pop." Workshop staff greeted her, client C stated "I'm leaving," and left the cafeteria. Client C walked for a few minutes and was seen heading for the exit door of the workshop. Client C exited the building, was followed by workshop staff, prompted to return to the workshop, and</p>						

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	<p>began to verbally threaten staff. Client C attempted to leave AWOL again from the workshop, was followed by staff, returned to workshop, and the residential provider was contacted to pick up client C. When the residential provider came to pick up the client C, police were contacted to assist with transporting the client to the inpatient unit at the behavioral hospital. The report indicated "Plan to resolve: Corvilla will continue to attempt to provide a safe environment for its residents (sic)."</p> <p>On 7/24/13 from 5:35pm until 7:10pm, Group Home Staff (GHS) #1, GHS #2, and Clients A, B, C, D, E, F, G, and H were at the group home. From 5:35pm until 6:02pm, clients A, B, C, D, E, F, G, and H were at the group home with two (2) staff (GHS #1 and GHS #2). At 6:02pm, GHS #1 left the group home with clients D and G to go grocery shopping. Clients A, B, C, E, F, and H were at the group home with one staff, GHS #2. From 6:02pm until 7:10pm, one (1) staff and six (6) clients, including client C, were at the group home and no one on one supervision of client C was provided during that time. During the observation period client C walked throughout the home into the dining room, up/down the hallway, bathrooms, kitchen, and the front living room with glass pictures, lamps,</p>				

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	<p>and decorative items without one on one staff. At 5:35pm, GHS #2 indicated client C had returned to the group home on 7/23/13 from the inpatient behavioral hospital.</p> <p>Client C's record was reviewed on 7/24/13 at 12:20pm. Client C's 3/19/12 BSP (Behavior Support Plan) indicated the target behavior of "Verbal Outburst: yelling, screaming, uncontrolled crying, and threatening physical aggression, Property Destruction: throwing personal items, hitting the walls with her fist, and throwing household items, Physical Aggression: attempting to hit staff and/or residents, actually hitting staff and/or residents; Elopement: When [client C] leaves the house without permission." Client C's BSP did not include PICA behavior of eating glass and inedible items.</p> <p>On 7/26/13 at 8:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated no plan had been developed to include client C's pica behavior of eating glass and other inedible items.</p> <p>This federal tag relates to complaint #IN00132940.</p>			

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	9-3-4(a)			

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W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client D), the facility failed to ensure client D's vision was assessed.</p> <p>Findings include:</p> <p>On 7/23/13 at 8:30am, client D's record was reviewed. Client D's record indicated she was admitted on 12/1/12 and did not indicate a vision evaluation. Client D's 1/17/13 Physician's History and Physical examination left "vision" blank on client D's form. Client D's 1/17/13 "Annual Health Summary" completed by the agency nurse indicated recommendation for client D: "...4. Vision examination yearly due to diabetes." Client D's 1/17/13 ISP (Individual Support Plan) indicated client D's diagnosis included, but was not limited to, "Diabetes."</p> <p>On 7/25/13 at 9:30am, an interview with the agency LPN (Licensed Practical Nurse) was conducted. The LPN indicated client D had not had a vision examination completed as of this date.</p> <p>9-3-6(a)</p>	W000323	Client D will have a vision exam following the physician's recommendation to have a vision exam. A vision exam is scheduled on 9-23-13 for client D with Dr. Robbins. All Corvilla residents will be checked and monitored quarterly by agency nurse to ensure the physician's recommendations are met and all forms are filed correctly.	08/30/2013			

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview for 5 of 27 doses of medications administered at the morning medication administration time, the facility failed to administer medications without error for clients F and H.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 7/23/13 at 6:20am, Group Home Staff (GHS) #3 administered client H's "Levothyroxine (for Thyroid) 50mcg (micrograms), 1 tab (tablet) orally every morning 30 minutes prior to eating." At 6:20am, GHS #3 gave client H her medication and client H took the medication with water. At 6:32am, client H consumed her first bite of the breakfast meal. On 7/23/13 at 1pm, client H's record was reviewed. Client H's 7/2013 MAR and 7/2013 "Physician's Order" both indicated "Levothyroxine 50mcg tablet, take 1 tablet orally every morning 30 minutes prior to eating." On 7/23/13 at 6:55am, GHS #3 administered client F's medications of 	W000369	<p>Client H will get her levothyroxine 30 minutes prior to eating. Staff will give medication at 6:30 am and then monitor the resident, keeping her busy with going to the bathroom, getting dressed etc before eating breakfast. All Corvilla home staff were trained that medication to be given on an empty stomach are to be given that medication with water 30 minutes prior to eating. All new staff will be trained in Medication Administration class during med pass demonstration and in three return demonstrations. Medications give without food will be monitored weekly at nurse's home visit and daily by managers in the home to ensure deficient practice will not re-occur. All staff will be checked annually by agency nurse on med pass demonstration to include giving medications given on an empty stomach.</p>	08/30/2013			

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	<p>"Celebrex (anti-inflammatory) 200mg (milligrams) 1 capsule orally once a day take with food, Potassium (for electrolytes) CL ER 8meg 2 tablets by mouth daily w/water pill (with water pill) take w/food, Calcium (for nutrition) 600mg + vit D (and vitamin D) give 1 tablet orally 2 times a day w/food, (and) Metformin HCL (for Diabetes) 500mg tablet, give 1 tablet orally 2 times a day take w/food-BKFT & Supper (take with food- Breakfast and Supper)." GHS #3 administered the medications in a spoonful of yogurt and no other food was offered. From 5:40am until 8:32am, client F had not consumed food.</p> <p>At 7:05am, client F's 7/2013 MAR and 7/2013 "Physician's Order" were reviewed and both indicated "Celebrex (anti-inflammatory) 200mg (milligrams) 1 capsule orally once a day take with food, Potassium (for electrolytes) CL ER 8meg 2 tablets by mouth daily w/water pill (with water pill) take w/food, Calcium (for nutrition) 600mg + vit D (and vitamin D) give 1 tablet orally 2 times a day w/food, (and) Metformin HCL (for Diabetes) 500mg tablet, give 1 tablet orally 2 times a day take w/food-BKFT & Supper (take with food- Breakfast and Supper)."</p> <p>On 7/25/13 at 9:30am, an interview with</p>						

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	<p>the agency LPN (Licensed Practical Nurse) was conducted. The LPN indicated the agency staff followed the "Living in the Community: Core A/Core B" medication training. The LPN indicated client F and H's medications should have been given according to their physician's orders. The LPN indicated client F and H's medications were given in error.</p> <p>On 7/25/13 at 10am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be administered according to the physician's order.</p> <p>9-3-6(a)</p>				

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W000391	<p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, for 1 of 27 medications observed administered at the morning medication administration (client G), the facility failed to ensure each medication was labeled.</p> <p>Findings include:</p> <p>On 7/23/13 at 6:27am, GHS (Group Home Staff) #3 selected client G's unlabeled container of Vaseline Petroleum Jelly from a plastic medication box on the medication closet. GHS #3 applied a pea size amount to client G's unwashed finger and unwashed forehead, and prompted client G to apply the Vaseline to her face. At 6:30am, GHS #3 indicated client G's unlabeled container of Vaseline did not have a pharmacy label, client G's name, nor client G's initials on the container to identify it belonged to client G. At 6:30am, client G's 7/2013 MAR (Medication Administration Record) indicated "Apply Vaseline to face after washing" twice a day for dry skin.</p> <p>On 7/25/13 at 9:30am, an interview with the agency LPN (Licensed Practical Nurse) was conducted. The LPN</p>	W000391	<p>Client G will have all medications labeled. Medication was labeled on 7-25-2013. All Bulla staff will be trained that all medication is to be labeled. All staff have been trained that a medication given to residents must be labeled. All new staff will be trained in Medication Administration class that any medication given to residents must be labeled. Medication given will be monitored for labels at nurse's weekly home visit and managers will monitor daily to ensure deficient practice will not re-occur. All staff will be checked annually by agency nurse on med pass demonstration to include that all medications given must be labeled.</p>	08/30/2013

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	<p>indicated the agency staff followed the "Living in the Community: Core A/Core B" medication training. The LPN indicated client G's Vaseline medication was purchased over the counter. The LPN indicated client G's Vaseline medication did not have an identification label or marking to signify it belonged to client G.</p> <p>On 7/25/13 at 10am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled.</p> <p>On 7/26/13 at 8:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client G's medication was not identified as belonging to client G.</p> <p>9-3-6(a)</p>				