

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
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NAME OF PROVIDER OR SUPPLIER CORVILLA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3202 S FELLOWS SOUTH BEND, IN 46614
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: September 21, 22, 23, 24, and 28, 2015.</p> <p>Facility Number: 001212 Provider Number: 15G636 AIMS Number: 100240190</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed by #09182 on 9/29/2015.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to ensure the environment of the facility was clean and in good repair for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 4 of 4 additional clients (clients #5,</p>	W 0104	In regards to tag W 104, the Maintenance Supervisor was consulted. The couch/ love seat that were found to be torn and ripped will be replaced by October 15, 2015. A new couch and love seat will be purchased to correct this issue. Corvilla had been looking for replacements prior to this survey. In regards to the carpet, the carpet was cleaned	11/15/2015

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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W 0130 Bldg. 00	<p>#6, #7, and #8).</p> <p>Findings include:</p> <p>The group home where clients #1, #2, #3, #4, #5, #6, #7, and #8 resided was inspected during the 9/22/15 observation period from 5:54 A.M. until 8:00 A.M. A love seat/couch was noted to have worn and torn leather on the seat cushions. The carpet in the north living room was soiled, and there were two holes in the wall above the couch in the south living room. The love seat/couch and other noted areas of the facility were utilized by clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/24/15 at 11:34 A.M. QIDP #1 stated, "The couch (love seat/couch) will be replaced and the carpet and wall will be cleaned and repaired."</p> <p>9-3-1(a)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p>		<p>professionally back in July at all of Corvilla's homes. Corvilla is now accepting bids to replace the carpet with tile or different carpeting. This is expected to be completed by November 15, 2015. In regards to the holes in the walls, they will be patched and repaired by October 9, 2015. To help prevent these issues in the future, Corvilla's QIDP's will go to all homes every other month and compile a list of repairs or maintenance needs such as carpeting, painting, landscaping, etc... In conjunction then with the Maintenance Supervisor, corrections will be made on a more regular basis.</p>				

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	<p>Based on observation and interview, the facility failed to provide privacy for 1 of 4 additional clients receiving prescribed medications (client #6).</p> <p>Findings include:</p> <p>Client #6 was observed during the 9/22/15 observation period from 3:41 P.M. until 5:15 P.M. At 4:26 P.M., client #6 was sitting in a chair waiting for his medications. Client #1 was sitting on the floor next to client #6. Direct care staff #7 retrieved client #6's medication and said, "Here is your stomach medication, [client #6]." Direct care staff #7 did not prompt or assist client #1 to leave the area prior to administering client #6 his medications nor did direct care staff #7 provide client #6 privacy for the administration of his (client #6's) medications.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/24/15 at 11:34 A.M. QIDP #1 stated, "Staff (direct care staff) should not talk about specifics of another client's meds in front of other clients."</p> <p>9-3-2(a)</p>	W 0130	<p>In regards to tag W 130, all staff was reminded that medications need to be given in privacy. In this case, staff failed to redirect another individual away from the medication area while giving medications to another individual. A memo was sent to the group homes and posted in each med closet. It states that before giving and discussing medications, look and make sure no one else is within ear shot before discussing medications with that individual. This will ensure everyone's' privacy is protected. In response the letter dated 10-7-15, all staff as stated above were reminded/trained by the House Manager/QIDP that medications are to be given in complete privacy As stated above, memos were posted in the med closets as reminders to staff when passing meds This will be monitored by the house manager during her shifts, random checks by the QIDP during his observations and checks by the nurse during her visits.</p>	10/01/2015	

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W 0137 Bldg. 00	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation and interview, the facility failed to assure 1 of 4 sampled clients (client #2), and 1 of 4 additional clients (client #6), wore clean shirts.</p> <p>Findings include:</p> <p>Clients #2 and #6 were observed during the group home observation period on 9/22/15 from 5:54 A.M. until 8:00 A.M. During the observation period, clients #1 and #2 spilled part of their morning meal onto their shirts. Direct care staff #1, #2, #3, and #4 did not assist or prompt the clients in putting on clean shirts.</p> <p>Clients #2 and #6 were observed during the group home observation period on 9/22/15 from 3:41 P.M. until 5:15 P.M. Upon arriving home from day program, clients #2 and #6 were wearing the soiled shirts they had on during the 9/22/15 morning observation. Direct care staff #5, #6, and #7 did not assist or prompt the clients in changing their shirts once arriving back at the group home.</p>	W 0137	<p>In regards to tag W 137, a memo was sent to the homes explaining that all clothes with food on them need to be changed immediately after the meal. It further states, they should never go anywhere with dirty clothes on. One staff will be designated to check each person before walking out the door for food being on their clothes. All of our folks take extra clothes to day program for this purpose so that will continue to be in place. Day services was also reminded that if they come in with food on their clothes to email the QIDP and change their clothes with the aforementioned extra clothing.</p> <p>In response to the letter dated 10-7-15, all staff were explained the memo by the house manager and they signed it acknowledging their understanding. As stated, one person will be assigned each shift if going out in the community to check all individuals' clothes before going out. It was also stated the Q will be notified by day services if they arrive with food on their clothes This will be done by the house manager or a designee. No one else has been</p>	10/01/2015

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	<p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/24/15 at 11:34 A.M. QIDP #1 stated, "Staff (direct care staff) should have assisted them (clients #2 and #6) in putting on clean shirts."</p> <p>9-3-2(a)</p>		<p>reported as wearing clothes with food of them by day program. The QIDP has not observed this while visiting day program.</p>		