

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER CORVILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1318 ROELKE ST SOUTH BEND, IN 46614		
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: July 25, 26, 29, 30, 31 and August 1, 2013.</p> <p>Facility number: 001217 Provider number: 15G671 AIM number: 100244670</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/12/13 by Ruth Shackelford, QIDP.</p>	W000000			

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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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review, the governing body failed to exercise general policy and operating direction over the facility to implement staff training and group home posting of the Elder Justice Act which had the potential to affect 5 of 5 clients (Clients #1, #2, #3, #4, and #5).</p> <p>Findings include:</p> <p>On 7/25/13 between 4:45 PM and 6:30 PM and on 7/26/13 between 6:30 AM and 7:30 AM, group home observations were conducted for all 5 clients (Clients #1, #2, #3, #4, and #5). No posting of the Elder Justice Act was observed.</p> <p>During an interview on 7/30/13 at 11:30 AM with the Executive Director and the Human Resource Director (HRD), the HRD indicated staff were not trained on the Elder Justice Act. The Executive Director indicated the facility did not train staff on the Elder Justice Act because the facility was unaware of the Elder Justice Act.</p> <p>During an interview on 7/31/13 at 10:54 AM, the QIDP (Qualified Intellectual Disabilities Professional) indicated the group home did not have the Elder Justice Act posted nor had staff been trained on the Elder Justice Act.</p> <p>9-3-1(a)</p>	W000104	The facility now has a Policy and Procedure in place addressing the Elder Justice. A copy of the Elder Justice Act has been placed in the Roelke home as well at the main office. All staff at Roelke have been trained in the implementation of the ELder Justice Act. In order to insure this deficiency does not occur in the future - a copy of the Elder Justice Act has been placed in all the homes and training of all staff in each home has been done. All new staff will be trained in the Elder Justice Act act at time of hire, The 'Q' will check in each home on weekly visits to make sure the Act is still hanging in a publice place in the home. Human Resources Manager will audit staff file at the time of hire and at least annually for existing staff to assure that all staff have been trained, Annually, at Corvilla All Staff training sessions the Elder Justice Act will be reviewed at the time we also go over Resident Right's and Reporting Abuse.	09/03/2013			

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on interview and record review for 1 of 3 sampled clients (Client #3), the facility failed to ensure the client's Individual Support Plan (ISP) included/indicated how facility staff were to provide additional monitoring for physical signs and symptoms of aspiration and aspiration pneumonia.</p> <p>Findings include:</p> <p>On 7/25/13 at 3:25 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed. A BDDS report dated 3/14/13 indicated on 3/14/13 at 4:40 AM staff "heard [Client #3] moan." The report indicated staff went to Client #3 and "found she had vomited. Staff cleaned her up and put her on her side to help breathing and in case of more vomiting." The report indicated Client #3 was breathing better and slept until 7:15 AM when Client #3's medications were given at bedside. The report indicated staff noticed during medication pass Client #3 "had (sic) hard time keeping eyes open." The report indicated Client #3 continued to appear lethargic and at 9:30 AM staff noticed "facial swelling." Staff took Client #3's vitals which were a blood pressure of 83/55 and a pulse of 82. The report indicated staff called 911 at that time. The report indicated Client #3 went to the emergency room and "was admitted with a diagnosis of acute respiratory failure with the possibility of aspiration pneumonia." The report indicated Client #3 was "critical."</p>	W000240	Client # 3 Individual Support Plan will ensure the facility staff will provide additional monitoring for physical signs and symptoms of aspiration and aspiration pneumonia. Client #3's Risk Management Plan/Dining has been updated to include aspiration pneumonia. Her eating recommendation include; she will sit up at a 90 degree angle for 45 minutes after eating and drinking. Staff response includes staff are to notify the nurse immediately if vomiting, choking, spitting up or wet cough is noted. Staff are also to take temp daily at 4:30 pm and notify the nurse is over 99 degrees. All Roelke and Day Program staff will be trained by 9-6-13. All Corvilla clients clients will be checked by agency nurse and risk management plan will be updated as needed. Staff will be monitored by agency nurse weekly and home managers daily to ensure this dificiendy does not occur again.	09/06/2013			

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	<p>-A follow up BDDS report dated 3/22/13 indicated Client #3 "does have a history of aspiration and has allergies and a great deal of resultant mucous. She is on a mechanical soft diet with nectar thick liquids." The report indicated on 3/22/13, Client #3 still had fluctuating oxygen levels as the level "went into the 70's, it had been 99, and she was put back on oxygen." The report indicated the use of a baby monitor device would be used upon her release to assist with overnight monitoring of Client #3.</p> <p>A BDDS report dated 4/5/13 indicated Client #3 had been released from the hospital with PRN (given as needed) oxygen. The report indicated on 4/4/13, Client #3's oxygen level was in the 70's while she was on her PRN oxygen. The report indicated Client #3 was taken by ambulance to the hospital. The report indicated Client #3 has a diagnosis of Raynaud's disease which causes poor circulation of hands and feet and can affect oxygen level readings.</p> <p>On 7/25/13 between 4:45 PM and 6:30 PM, group home observations were conducted. At 5:44 PM, Client #3 was observed to self ambulate in a wheelchair wearing a seat belt down the hallway to the bathroom. Direct Support Professional (DSP) #1 unlatched Client #3's seat belt and assisted her into the restroom grasping her gait belt. At 5:55 PM, DSP #2 assisted Client #3 to ambulate to the dining room table by holding her gait belt while she walked. At 6:08 PM, Client #3 was observed during dinner to eat using a plate guard. Client #3 ate a mechanical soft dinner of chicken, corn, green beans, and mashed potatoes. Client #3 had nectar thick lactose free milk to drink. On 7/26/13 between 6:30 AM and 7:30 AM, during group home observations, Client #3 was observed to eat her breakfast. Client #3 was being assisted in eating cereal when she began to make noises in</p>						

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	<p>attempt to burp. DSP #3 encouraged Client #3 to burp if she needed to and after two burps, Client #3 vomited cereal back into her bowl.</p> <p>On 7/26/13 at 12:55 PM during day service observation, Client #3 was observed after lunch sitting in her wheelchair with her seat belt latched. During an interview on 7/26/13 at 1:10 PM with day service staff, DSP #4 stated Client #3 "has congestion all the time." DSP #4 indicated the day service program was not given a risk plan for pneumonia for Client #3 but indicated she would call the group home if Client #3 acted out of the ordinary. DSP #4 indicated Client #3 had not eaten all of her lunch. DSP #4 indicated Client #3 did not eat her jello or applesauce.</p> <p>Record review on 7/29/13 at 11:00 AM indicated Client #3's diagnoses included, but were not limited to, seizures, intellectual disabilities, upset stomach, allergies, down syndrome, Raynaud's disease, and constipation. Client #3's physician's order dated 7/1/13 indicated a regular diet of mechanical ground, reduced lactose diet, and nectar thick liquids.</p> <p>Client #3's ISP (Individual Support Plan) dated 3/7/13 indicated risk plans for dining. Client #3's dining plan indicated Client #3 was at risk for "choking" and "aspiration." Client #3's dining plan recommended staff monitor Client #3 "for small bites, encourage her to sit upright, alternate drink and bite, and discourage mixed consistencies." Client #3's dining plan indicated staff should "notify nurse if vomiting or choking occurs" and take Client #3's temperature, pulse, and blood pressure monthly and PRN (as needed). Client #3's ISP also indicated Client #3 had undated night time "Aspiration Guidelines." Client #3's night time aspiration guidelines included the following:</p>			

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	<p>"1. Elevate head of bed 30 degrees at all times. 2. Check every hour when she is in bed for breathing, congestion, vomiting. 3. Have baby monitor on at all times when [Client #3] is in bed. Listen for changes in breathing, snoring, congestion, or vomiting. 4. Turn on side, prop with pillow at back, check that [Client #3] is on side hourly. 5. Report changes and concerns to nurse immediately."</p> <p>Review of Client #3's hospital discharge summary from 3/14/13 indicated Client #3 presented with acute respiratory failure, aspiration pneumonia, hypotension, and sepsis.</p> <p>On 7/31/13 at 10:54 AM, the QIDP (Qualified Intellectual Disabilities Professional) was interviewed and indicated the facility nurse develops client risk plans. The QIDP indicated the group home added a night time monitoring device for added monitoring of Client #3 for aspiration but did not add signs and symptoms of aspiration and aspiration pneumonia to her risk plans.</p> <p>On 7/31/13 at 1:20 PM, the LPN (Licensed Practical Nurse) was interviewed and indicated she was still developing her system of identifying which client medical risks would warrant a high risk plan. The LPN indicated Client #3's dining risk plan was not updated to include the physical signs and symptoms of aspiration other than choking, congestion, and vomiting. The LPN indicated Client #3's dining risk plan was not updated to include the signs and symptoms of pneumonia after Client #3's hospital stay in 3/2013.</p> <p>9-3-4(a)</p>						

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