STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15G671		06/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORVILLA INC	1318 ROELKE ST SOUTH BEND, IN 46614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: May 26, 27, 28, 29, and June 1, 2015. Facility number: 001217 Provider number: 15G671 AIM number: 100244670 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to ensure carpeting in the hallway, foyer, and living room of the facility was clean and in good repair for 2 of 2 sampled clients (client #1 and #2), and 1 additional client (client #3). Findings include:	W 0104	The maintenance supervisor scheduled all homes carpet to be professionally cleaned on June 8, 2015. The carpet is now clean. He will schedule a regular cleaning cycle to maintain the appearance of the carpeting The house manager will inspect them on a daily basis and report any issues immediately The QIDP will inspect during home visits	06/08/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	The group home where clients #1, #2, and #3 resided was inspected during the 5/26/15 observation period from 3:27 P.M. until 5:30 P.M. Carpeting in the hallway, foyer, and living room of the facility was faded and stained throughout. The carpeting in the facility was utilized by clients #1, #2, and #3. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 5/28/15 at 10:37 A.M. QIDP #1 stated, "I'm aware of the condition of the carpet at the group home. We are deciding whether to have it cleaned or replaced." 9-3-1(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, the facility failed to assure	W 0249	All staff was retrained on Client#1's behavior plan on June 11, 2015. Staff was trained on	06/11/2015

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	direct care staff implemented the behavior plan of 1 of 2 sampled clients (client #1). Findings include: Client #1 was observed at the group home during the 5/26/15 observation period from 3:27 P.M. until 5:30 P.M. At 4:15 P.M., client #1 was moving herself to the living room using her wheelchair. While passing client #3, client #1 began hitting client #3 with an open hand. Client #3 became upset and started slapping at client #1's hand. During the incident, direct care staff #1 was standing directly behind client #1. Direct care staff #1 did not redirect client #1 and did not intervene in any manner. Client #1's records were reviewed on 5/27/15 at 8:34 A.M. A review of client #1's 8/16/14 Behavior Plan indicated client #1 displays target behaviors which included, but were not limited to, physical aggression. Client #1's Behavior Plan further indicated direct care staff were to redirect client #1 if the client began to physically aggress toward others. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 5/28/15 at 10:37 A.M. QIDP #1 stated,		how to redirect client #1 during times of physical aggression as per the behavior plan. All behavior plans were reviewed with staff. To ensure this does not continue to happen, the QIDP will quiz staff monthly on all behavior plans in the home and also ensure staff is following the behavior plans during the QIDP's home observations. The house manager will ensure on a daily basis that the behavior plan is being followed and to report any issues to the QIDP of staff non-compliance.	

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	"Staff (direct care staff #1) should have implemented [client #1's] behavior plan. They (direct care staff #1) should have redirected her (client #1)." 9-3-4(a)			
W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview, the facility failed to ensure the Comprehensive Functional Assessment for 1 of 2 sampled clients (client #2) was reviewed at least annually. Findings include: Client #2's record was reviewed on 5/27/15 at 9:44 A.M. The review indicated the client's most current Comprehensive Functional Assessment was dated 1/21/14. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 5/28/15 at 10:37 A.M. QIDP #1 stated,	W 0259	The functional assessment for client #2 was completed on June3, 2015. The QIDP checked all other comprehensive functional assessments to ensure they were current. The QIDP also created a checklist with everyone's current functional assessment date and when a new one will need to be completed.	06/03/2015

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	"It (Comprehensive Functional Assessment) was not done (since 1/21/14). It must have been overlooked." 9-3-4(a)			
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview, the facility failed to assure 1 of 2 sampled client's (client #2's) beverages were of nectar thick consistency. Findings include: Client #2 was observed during the 5/26/15 observation period from 3:27 P.M. until 5:30 P.M. At 4:48 P.M., direct care staff #2 retrieved a soda pop from the counter and opened it. Direct care staff #2 stated to client #2, "Here, I'll share this with you." Direct care staff #2 poured the soda pop into two glasses and gave one glass to client #2. Client #2 drank the soda pop. The soda pop was not nectar thick. Client #2's record was reviewed on	W 0460	All staff was retrained by the Corvilla nurse on Client #2's prescribed diet that requires all liquids to be nectar thick. The QIDP will ensure this is being done on his weekly visits to the home. The manager will ensure staff is following the prescribed diet on a daily basis. The nurse will ensure this is being done during her weekly visits to the home. Any variances will be corrected at once and reported to the QIDP for further corrective action.	06/11/2015

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	5/27/15 at 9:14 A.M. Review of the client's 3/5/15 nutritional assessment indicated the client was to have "Nectar Thickened Liquids." Nurse #1 was interviewed on 5/27/15 at 10:29 A.M. Nurse #1 stated, "Staff (direct care staff #2) should have made sure [client #2's] drink (soda pop) was nectar thick." 9-3-8(a)			
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, record review, and interview, the facility failed to assure 1 of 2 sampled clients (client #1) participated in family style dining to the full extent of her assessed capabilities. Findings include: Client #1 was observed during the group home observation period on 5/26/15 from 3:27 P.M. until 5:30 P.M. During the	W 0488	To ensure that each resident participates in preparing and serving meals to each of their abilities, a weekly chore chart will be developed. This will be a rotating list of chores. The QIDP will compile the chart and train the house manager. The house manager will explain the chore chart to all staff. The house manager will ensure this is followed on a daily basis. The QIDP will monitor compliance through his home observations.	06/15/2015

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	observation, direct care staff #1 prepared coffee for client #1 and gave it to the client as the client sat at the dining room table. Direct care staff #1 prepared baked fish, scalloped potatoes, and green beans for the evening meal. Direct care staff #1 set the table and placed the foods in serving dishes and then on the table. Direct care staff #1 placed servings of the foods on client #1's plate and poured beverages for the client. Client #1 did not participate in the preparation of the evening meal. Client #1 was observed during the group home observation period on 5/27/15 from 6:32 A.M. until 8:00 A.M. During the observation, direct care staff #1 prepared coffee for client #1 and gave it to the client as the client sat at the dining room table. Direct care staff prepared oatmeal, pineapple segments, and juice for the morning meal. Direct care staff #1 set the table and placed the foods in serving dishes and presented them to client #1 at the dining room table. Client #1 did not participate in the preparation of the morning meal. Client #1's records were reviewed on 5/27/15 at 8:34 A.M. A review of the client's Comprehensive Functional Assessment, dated 5/22/14 indicated client #1 was capable of participating in		The house manager will report any staff not following the chart and corrective action will occur.	

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	the preparation of her meals with verbal prompts and hand over hand assistance from direct care staff. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 5/28/15 at 10:27 A.M. QIDP #1 stated, "[Client #1] is capable of participating in meal preparation with assistance from staff." 9-3-8(a)			