

| | | | |
|--|---|--|---|
| 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 06/22/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CORVILLA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 18443 BULLA RD SOUTH BEND, IN 46637 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|---|---------------|---|----------------------|
| W0000 | <p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: June 20, 21, and 22, 2012</p> <p>Facility number: 000740 Provider number: 15G214 AIM number: 100234800</p> <p>Surveyor: Susan Eakright, QMRP/Medical Surveyor III</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on June 29, 2012 by Dotty Walton, Medical Surveyor III.</p> | W0000 | | |

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.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 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 06/22/2012 | |
| NAME OF PROVIDER OR SUPPLIER CORVILLA INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 18443 BULLA RD SOUTH BEND, IN 46637 | | | |
| (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 | | | |
| W0126 | <p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation, record review, and interview, for 3 of 4 sampled clients (clients #2, #3, and #4), the facility failed to encourage and teach the use of United States currency during times of opportunity.</p> <p>Findings include:</p> <p>Observations were conducted on 06/21/12 from 5:45 am until 8 am, at the facility. At 7:45 am, GHS (Group Home Staff) #1 retrieved a clear plastic container with cardboard quarters, dimes, nickels, and pennies inside the container. At 7:45 am, GHS #1 asked client #2 "Do you want to complete your money goal?" Client #2 responded "yes." GHS #1 placed two cardboard quarters on the table. When asked if the cardboard was real. Client #2 responded "yes." At 7:50 am, clients #3 and #4 indicated they used the same cardboard coins to identify coins. At 7:50 am, GHS #1 stated the cardboard coins were used "for all clients living in the group home" to identify coins and implement objectives. At 7:50 am, client</p> | W0126 | <p>To ensure the rights of clients #2, 3, and 4, the QMRP has met with the Bulla Managers and instruced them that whenever they are implementong a a money management goal; they must use United States currency only. Thereby ensuring each resident is afforded the opportunity to be taught to manage their own financial affairs to the best of theri ability. The Managers will be responsible for instructing\training their staff on the ues of United State currency when implementing money management goals. Completion Date - July 22, 2012 Responsible Person - QMRP Addendum: The QMRP will be responsible to monitor the staff and their adherence to the training they have been provided regarding the use of U.S. currency only on at least a monthly basis. The Manangers will be responsible for removing all non U.S. currency products. The QMRP will review all goals and objectives on a monthly basis to ensure the training is effective. Responsible Person: Anedria Gibson Completion Date: July 22, 2012</p> | 07/22/2012 | | | |

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 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 06/22/2012 | |
| NAME OF PROVIDER OR SUPPLIER CORVILLA INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 18443 BULLA RD SOUTH BEND, IN 46637 | | | |
| (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 | | | |
| | <p>#1 indicated she used real coins.</p> <p>Client #2's records were reviewed on 06/21/12 at 12:40 PM. Client #2's 4/12/12 ISP (Individual Support Plan) indicated client #2's goal was to make change from \$1.00.</p> <p>Client #3's records were reviewed on 06/21/12 at 10:50 AM. Client #3's 1/26/12 ISP indicated client #3's goal was to identify dimes and quarters to make change from \$2.00.</p> <p>Client #4's records were reviewed on 6/21/12 at 11:35 AM. Client #4's 7/14/11 ISP indicated a goal to make change from \$3.00.</p> <p>The QDP (Qualified Developmental Professional) was interviewed on 06/21/12 at 9:20 AM. The QDP indicated the play replica money was not the same as using U.S. bills and coins. The QDP indicated U.S. coins and bills should have been used at each opportunity.</p> <p>9-3-2(a)</p> | | | | | | |

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 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 06/22/2012 | |
| NAME OF PROVIDER OR SUPPLIER CORVILLA INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 18443 BULLA RD SOUTH BEND, IN 46637 | | | |
| (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 | | | |
| W0323 | <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 #3), the facility failed to ensure client #3's vision was reassessed as recommended.</p> <p>Findings include:</p> <p>On 6/21/12 at 10:50 am, client #3's record was reviewed. Client #3's 3/29/10 vision evaluation indicated recommendation to wear her prescribed eye glasses and "to be seen every 2 years." Client #3's 1/26/12 ISP (Individual Support Plan) indicated she wore prescribed eye glasses. Client #3's 1/26/12 "Annual Health Screening" completed by the agency nurse indicated "Vision: 3/29/10 Glasses constant wear, Q2yr (every two years)." Client #3's 3/23/12 "Annual Physical" did not review her identified visual need.</p> <p>On 6/22/12 at 9:20 am, an interview with the QDP (Qualified Developmental Professional) and with telephone contact with the LPN (Licensed Practical Nurse) was completed. The QDP and the LPN both indicated client #3 had not been reassessed for her visual needs. The QDP indicated client #3 wore glasses.</p> | W0323 | Client #3 had a vision exam on 7-5-12. Corvilla will follow the doctors recommendations to have an eye exam every 2 years.To ensure physician's recommendation are met in a timely manner, the Nurse will be responsible for reviewing and monitoring each Corvill resident file on a quarterly basis to determine the need for for an evaluation and for scheduling that appointment.Responsible Person - Corvilla NurseCompletion Date: July 22, 2012 | 07/22/2012 | | | |

| 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 06/22/2012 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER CORVILLA INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 18443 BULLA RD SOUTH BEND, IN 46637 | | |
| (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 | |
| | 9-3-6(a) | | | | |

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 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 06/22/2012 | |
| NAME OF PROVIDER OR SUPPLIER CORVILLA INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 18443 BULLA RD SOUTH BEND, IN 46637 | | | |
| (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 | | | |
| W0330 | <p>483.460(b)(2) PHYSICIAN PARTICIPATION IN THE IPP If appropriate, physicians must participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.</p> <p>Based on record review and interview, for 1 of 1 sample clients (client #4) who received PRN (as needed) medications given for behavior, the facility failed to communicate the use of PRN behavioral medications to client #4's psychiatrist.</p> <p>Findings include:</p> <p>On 6/21/12 at 11:35 am, client #4's records were reviewed. Client #4's 5/1/12 "Physician's Order" included "Seroquel 200 mg (milligrams) PRN for agitation (signed by client #4's physician)." Client #4's 3/19/12 BSP (Behavior Support Plan) indicated the use of "Seroquel 200 mg PRN for agitation." Client #4's 3/19/12 BSP indicated "Guidelines (for) [client #4's] PRN Seroquel. When [client #4] becomes agitated or aggressive and cannot be calmed down using behavior plan, staff should call the nurse to discuss possibility of giving Seroquel 200 mg PRN." Client #4's Monthly Nurses Notes indicated the following dates for the use of PRN Seroquel: on 1/27/12, on 1/4/12, and on 8/9/11. Client #4's Psychiatric Reviews were completed on 4/24/12,</p> | W0330 | <p>Client #4 Psychiatrist will be notified of all PRN behavioral medication when give. Client t #4's Psychiatrist will be notified of the PRN medication give on 8/9/11 , 1/4/12 1/27/12 at the appointment on 7/7/12. The Nurse will be responsilbe for notifying the psychiatrist of all PRN behavioral medications given to ensure physician participation in the IPP. The Nurse will review all PRN behavioral medications when filling out the Corvilla Psychiatric Evaluation Appointment Record that is provided to the doctor at each appointment. This protocol will be used for all Corvilla residents in every home. Completion Date: July 22, 1212Responsible Person: Corvilla Nurse</p> | 07/22/2012 | | | |

| | | | |
|--|---|--|---|
| 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 06/22/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CORVILLA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 18443 BULLA RD SOUTH BEND, IN 46637 |
|--|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| | <p>1/24/12, 1/6/12, 11/1/11, and 8/9/11 and did not indicate the facility administered client #4's PRN Seroquel medication for behavior.</p> <p>On 6/22/12 at 9:20 am, an interview with the QDP (Qualified Developmental Professional) and by telephone with the LPN (Licensed Practical Nurse) was conducted. Both indicated client #4's PRN Seroquel 200 mg was given because of behaviors on 1/27/12, 1/4/12, and 8/9/11. The QDP and the agency LPN both indicated the three incidents of use were not reported to client #4's Psychiatrist.</p> <p>9-3-6(a)</p> | | | |

| 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 06/22/2012 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER CORVILLA INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 18443 BULLA RD SOUTH BEND, IN 46637 | | |
| (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 | |
| W9999 | <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>460 IAC 9-3-1 Governing body</p> <p>Sec. 1. (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, for 3 of 3 PRN (as needed) medications given for behavior (client #4), the facility failed to immediately report to BDDS (the Bureau of Developmental Disabilities Services) the use of as needed (PRN) behavior medication use.</p> <p>Findings include:</p> <p>The facility's BDDS reports were reviewed on 6/20/12 at PM, and did not indicate the use of client #4's PRN behavioral medication.</p> | W9999 | Corvilla will follow the current BDDS policy of reporting all PRN medications given for behavioral issues to the division by telephone no later than the first business day then followed by written summaries. This protocol will be followed in all Corvilla homes. Responsible Persons - Nurse and QMRP. | 07/22/2012 | |

| | | | | | |
|--|--|---|---|----------------------|---|
| 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 06/22/2012 |
| NAME OF PROVIDER OR SUPPLIER CORVILLA INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 18443 BULLA RD SOUTH BEND, IN 46637 | | |
| (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 | |
| | <p>On 6/21/12 at 11:35 am, client #4's records were reviewed. Client #4's 5/1/12 "Physician's Order" included "Seroquel 200 mg. (milligrams) PRN for agitation (signed by client #4's physician)." Client #4's 3/19/12 BSP (Behavior Support Plan) indicated the use of "Seroquel 200 mg. PRN for agitation." Client #4's 3/19/12 BSP indicated "Guidelines (for) [client #4's] PRN Seroquel. When [client #4] becomes agitated or aggressive and cannot be calmed down using behavior plan, staff should call the nurse to discuss possibility of giving Seroquel 200 mg. PRN." Client #4's Monthly Nurses Notes indicated the following dates for the use of PRN Seroquel: on 1/27/12, on 1/4/12, and on 8/9/11.</p> <p>On 6/22/12 at 9:20 am, an interview with the QDP (Qualified Developmental Professional) and by telephone with the LPN (Licensed Practical Nurse) was conducted. Both indicated client #4's PRN Seroquel 200 mg. was given because of behaviors on 1/27/12, 1/4/12, and 8/9/11. The QDP and the agency LPN both indicated the three incidents of use were not reported to BDDS.</p> <p>On 6/20/12 at PM, the 3/1/11 BDDS policy was reviewed and indicated "Reportable Incidents: Incidents to be reported to BDDS include any event or</p> | | | | |

| 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 06/22/2012 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER CORVILLA INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 18443 BULLA RD SOUTH BEND, IN 46637 | | |
| (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 | |
| | <p>occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to...18. Use of any PRN medication related to an individual behavior."</p> <p>9-3-1(b)</p> | | | | |