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| 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 11/14/2012 |
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| NAME OF PROVIDER OR SUPPLIER CORVILLA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1318 ROELKE ST SOUTH BEND, IN 46614 |
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| W0000 | <p>This visit was for the investigation of Complaint #IN00118218.</p> <p>Complaint #IN00118218: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149.</p> <p>Dates of Survey: November 13 and 14, 2102.</p> <p>Facility number: 001217 Provider number: 15G671 AIM number: 100244670</p> <p>Surveyor: Tim Shebel, Medical Surveyor III</p> <p>The following federal deficiency also reflects a state finding in accordance with 460 IAC 9.</p> <p>Quality review completed November 16, 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.

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| W0149 | <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 record review and interview, the facility neglected for one of one incident reviewed affecting one additional client (D), to implement the facility's abuse/neglect policy to assure a wheelchair was securely strapped in the van before transporting client D.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 11/12/12 at 11:12 A.M.. A review of incident reports from 8/1/12 to 11/13/12 indicated the following incident involving client D:</p> <p>"Name: [Client D], Date: 10/15/2012, Narrative Details: Residents were loaded into the van for morning transport to Day Program. The 2 staff and 5 ladies (clients) had only gotten about 100 yards from the home when they made a left turn. [Client D's] wheelchair with [client D] in it turned over. [Client D] hit her head of the floor. Staff applied pressure to the cut on [client D's] head, righted the wheelchair and returned to the house. The 4 ladies and one staff stayed at the group home and [client D] was taken to [name of hospital] emergency room.</p> | W0149 | <p>An investigation was done by the QMRP. It was determined that direct care staff #7 was responsible for the incident which we felt resulted in neglect. She was given a a official reprimand which will remain in her personel file. This was done on 10\18\2012. Direct care staff #7 was retrained on wheelchair tie downs on 10\18\2012 before she worked with tie downs again. There are 2 residents who use wheel chairs and both have the potenial to be affected by staff member #7 deficient practices. A corrective plan that has been implemented will protect any residents who uses wheelchairs. We have made the following systematic change. The morning van driver will check the tie downs that staff #7 does and any/all times the staff #7 does the tie downs. There are always 2 staff members every morning for transport - If they have problems, the QMRP will come and assist. This will ensure there are always a fully trained staff availabe to check the tie downs. The corrective measures will be monitored by the House Managers, van driving staff and the QMRP. All training and corrective measures were</p> | 11/16/2012 | | | |

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| | <p>There she had 3 staples inserted to close the cut. A scan of of her head was normal which medical staff said ruled out a concussion. Also, there was no bump present. She (client D) is to follow up with her family doctor in 10 days. She may take over the counter pain medication. She was released to normal activities and was home before noon. Plan to Resolve: The QMRP (Qualified Mental Retardation Professional) interviewed the staff on duty. [Direct care staff #7] said it was her fault even before I asked. She reports that she fastened the 2 rear wheelchair tie downs for [client D's] chair. She then came around to the front of the wheelchair to fasten those tie downs. She (direct care staff #7) was distracted by another client asking her to fastened her seatbelt. She fastened that belt and forgot about the front tie downs of [client D's] chair. She realized what she had done as soon as she heard [client d's] chair go over. [Direct care staff #7] was quite emotional and has taken full responsibility for [client D's] injuries. [Direct care staff #7] was trained in how to do wheelchair tie downs in April (4/12) when she started. AS THE PLAN OF CORRECTION for this incident, she will be trained again at length on how to safely secure wheelchairs in our van. Since she had already took (sic) responsibility for the incident, it was decided that no</p> | | <p>completed by 10\18\2012 and will be monitored going forward. The surveyor has copies of above stated issues; retraining documents, reprimand of staff #7, memos to all of the staff regarding the new protocol regarding the double check by a second staff of the tie downs. The surveyor took the papwork with him when he did the exit interview. Responsible Persons: House Managers and QMRP.</p> | | | | |

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| | <p>disciplinary action be taken at this time."</p> <p>The facility's records were further reviewed on 11/14/12 at 9:07 A.M.. Review of the 10/19/12 follow up to the 10/15/12 incident indicated direct care staff #7 was off of the work schedule until 10/18/12 and retrained in wheelchair tie downs on 10/18/12.</p> <p>QMRP #1 was interviewed on 11/14/12 at 9:16 A.M.. QMRP #1 indicated direct care staff #7 was neglectful in not fully securing client D's wheelchair in the van before transporting the client on 10/15/12 which resulted in injury to client D.</p> <p>The facility's records were reviewed on 11/14/12 at 10:57 A.M.. A review of the facility's "Personnel Policy and Procedure Abuse or Neglect of Residents by Agency Staff", no date, indicated, in part, the following: "II. NEGLIGENCE of a client shall consist of any of the following acts: 1.) 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."</p> <p>This federal tag relates to complaint #IN00118218.</p> <p>9-3-2(a)</p> | | | | | | |

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