

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G377	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 52549 MYRTLE ST SOUTH BEND, IN 46637		
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: July 23, 24, 25, 26, 29, 31, and August 1, 2013</p> <p>Facility Number: 000891 Provider Number: 15G377 AIM Number: 100244320</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/7/13 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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W000130	<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>Based on observation and interview for 1 of 2 sampled clients (client #2) and for 2 additional clients (clients #1 and #3), the facility failed to encourage and teach personal privacy during client #1, #2, and #3's morning routine.</p> <p>Findings include:</p> <p>On 7/24/13 at 6:15am, client #1 walked nude from his bedroom, carried his folded clean clothing outfit for the day, and entered the hallway bathroom. Group Home Staff (GHS) #1 did not prompt or encourage client #1 to wear a robe or covering. At 6:30am, client #1 walked up and down the bedroom hallway nude with no redirection from GHS #1. At 6:30am, client #3 stood nude inside the doorway to his bedroom and dressed with the bedroom door open to view of the hallway with no staff redirection. At 6:30am, client #2 entered the hallway bathroom without knocking and was dressed in his underwear shorts. Client #1 was nude in the same bathroom and was stepping into the shower. There was no redirection of client #2 from staff. Client #2 brushed his teeth and used the</p>	W000130	To ensure the right to privacy for clients # 1, 2 and 3 during car of personal needs and treatment, the QIDP has re-trained the staff at Myrtle on Resident Rights with a major focus on encouraging privacy during the morning routine (bathing and dressing). To ensure a deficiency of this nature does not happen in the future, the staff has been instructed by the QIDP to monitor the home closely when the men are preparing to dress for the day or for bed time. The QIDP will be responsible for visiting each of Corvilla's homes weekly to ensure compliance with each client's right to privacy during the morning routine.	08/27/2013			

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	<p>toilet while client #1 was showering. At 6:40am, client #2 exited the bathroom dressed in his underwear shorts.</p> <p>On 7/26/13 at 8:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated clients should have privacy and be taught personal privacy during their morning routine. The QIDP indicated she was unsure if clients #1, #2, or #3 owned a robe.</p> <p>9-3-2(a)</p>			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, record review, and interview for 1 of 2 sampled clients (client #4), the facility failed to implement medication goals when opportunities existed.</p> <p>Findings include:</p> <p>On 7/23/13 at 4:16pm, GHS #2, without client #4 present, popped from a medication card into a medication cup and assembled client #4's oral medications of "Gemfibrozil 600mg tablet, give 1 tablet orally 2 times a day (for health), Clonazepam (for behaviors) 1mg, give 1 tablet orally 3 times a day, Gabapentin 300mg, give 2 capsules orally 3 times a day (for behaviors), (and) Oxcarbazepine 600mg, give 1 tablet 4 times a day (for behaviors)." GHS #2 called client #4 to the medication area and GHS #2 gave client #4 the medication cup with the five doses of medication. Client #4 took the medication and left the medication area and no teaching or specific training about client #4's</p>	W000249	To ensure that Client #4 receives continous active treatment programming, the QIDP has reviewed/re-trained the staff on Client' #4's medication adminstration program.. The staff was also re-trained on the other resident's medication administration programs. The staff has been instructed that all medication programs are to be run at each medication pass and documented a minimum of one time daily. The QIDP will ensure that there are no other deficiencies of this nature in the future; the QIDP will be responsible for visiting the home weekly to observe a med pass and monitoring the documentation of the goals monthly	08/27/2013			

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	<p>medication was completed. At 4:16pm, GHS #2 indicated client #4 did not have an objective/goal to teach him about his medications.</p> <p>On 7/25/13 at 10:35am, client #4's record was reviewed. Client #4's 6/13/13 Individual Support Plan (ISP) and record indicated a goal/objective dated 7/1/13 to state why he receives Clonazepam daily.</p> <p>On 7/25/13 at 9:30am, an interview with the agency LPN (Licensed Practical Nurse) was conducted. The LPN indicated the staff should have implemented each client's medication goal/objective.</p> <p>On 7/26/13 at 8:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated staff should have implemented client #4's medication objective/goal.</p> <p>9-3-4(a)</p>			

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W000371	<p>483.460(k)(4) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on observation, interview and record review for 1 of 4 sampled clients (client #2), the facility failed to ensure the client received medication training on a specific medication.</p> <p>Findings include:</p> <p>On 7/23/13 at 3:55pm, Group Home Staff (GHS) #2, without client #2 present, popped from a medication card into a medication cup and assembled client #2's oral medications of "Propranolol (for headaches) 20mg (milligrams) 1 tab (tablet) orally once a day (and) Buspirone (for explosive behaviors) 10mg, give one tablet orally 3 times a day." GHS #2 called client #2 to the medication area, asked him what time his medications were given daily, client #2 responded, and GHS #2 gave client #2 the medication cup with the two tablets. Client #2 took the medication and left the medication area. No teaching or specific training about client #2's medication was completed.</p> <p>On 7/25/13 at 9:10am, client #2's record</p>	W000371	Client #2 will receive medication training on specific medications. Client #2's home staff will be taught to give name of medication and reason for taking it at each med pass. All residents at Myrtle will receive medication training on all medications on the name of the medication and the reason it is given. All Corvilla staff will receive specific training on each medication give at the next Corvilla All staff Meeting.	09/06/2013	

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	<p>was reviewed. Client #2's 10/18/12 ISP (Individual Support Plan) indicated a goal/objective to state when medication passes were completed.</p> <p>On 7/25/13 at 9:30am, an interview with the agency LPN (Licensed Practical Nurse) was conducted. The LPN indicated the client worked on one item at a time for the medication goal.</p> <p>9-3-6(a)</p>						

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W000455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview, for 2 of 2 sampled clients (clients #2 and #4) and for 2 additional clients (clients #1 and #3), the facility failed to teach personal hygiene practices for the prevention of infection control and a maintain a sanitary environment when opportunities existed.</p> <p>Findings include:</p> <p>On 7/23/13 at 3pm until 5:35pm, clients #1, #2, #3, and #4 were at the group home. At 4:45pm, Group Home Staff (GHS) #2 requested client #4 to set the dining room table for supper, client #4 washed his hands with GHS #3, and then went to the kitchen cabinet. At 4:45pm, client #4 rubbed his face and hair and no hand washing was taught or encouraged. At 4:45pm, client #4 handled the spoons from a drawer in the kitchen by the food contact ends and put each spoon at each of the four place settings on the table. At 4:55pm, client #4 was prompted by GHS #3 to carry and set the dessert dishes and glasses on the dining room table. Client #4 placed his fingers inside each of the stacked dessert dishes and placed each dish on the table at the table service. Client #4 placed his fingers inside each of</p>	W000455	All staff are trained in Universal Precautions and Infectious Diseases in Medication Administration. Staff are trained to have residents wash hands to avoid spreading organisms that cause disease. All Myrtle staff are trained to observe personal practices of clients and to redirect clients to wash hands and give verbal reminders not to touch body parts during meal preparation. Clients are to be instructed on touching only the parts of utensils and dishes where food does not touch. All Myrtle staff were re-trained on 8-30-2013. All Corvilla residents will be monitored for using proper hand washing at proper times. All Corvilla residents will be taught and monitored for proper touching of utensils and dishes. All Corvilla staff were trained to observe, redirect and train residents as needed on 8-30-2013	08/30/2013	

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	<p>the stack of glasses and placed the glasses on the dining room table. No staff redirection was observed. At 5:15pm, clients #1, #2, #3, and #4 sat at the dining room table, one client at each of the four place settings. Clients #1, #2, #3 and #4 used the spoons, glasses, and dessert table service client #4 had placed his fingers inside or on the food contact area.</p> <p>An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 7/26/13 at 8:10am. The QIDP indicated staff should have redirected client #4 to wash his hands before continuing to set the dining room table for supper and staff should have redirected client #4 to wash his hands after touching his face and hair.</p> <p>9-3-7(a)</p>			

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W009999	<p>State Findings</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 1 of 1 incident of evacuating the group home during a weather related emergency (clients #1, #2, #3, and #4), the facility failed to report the emergency evacuation to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law.</p> <p>Findings include:</p> <p>On 7/24/13 at 3:00pm, the facility's "Evacuation Drills" for the period from 7/2012 through 7/2013 were reviewed. The review indicated a "Fire Watch" was initiated by the facility staff on duty because a storm had moved through the area and the group home had lost power at 9:30pm. The "Fire Watch" report</p>	W009999	To ensure that all incidents of evacuation are reported in a timely manner the QIDP will re-trained on Corvilla's Incident and BDDS policy on reporting. The Executive Director will meet on an annual basis with the QIDP for a refresher on each policy. To ensure that a deficiency of this nature does not occur again the QIDP will develop and implement a call in system whereby a reminder/message will be left in order to aid the QIDP in reporting incidents in a timely manner.	08/02/2013			

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	<p>indicated it was completed from 9:30pm until 10:30pm. The "Fire Watch" report indicated when the staff for the overnight period came on duty, the QIDP (Qualified Intellectual Disabilities Professional) was called and the group home was evacuated to a hotel on 6/24/13.</p> <p>On 7/23/13 at 9:55am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 07/2012 through 07/23/13 and did not include the 6/24/13 at 11:00pm incident of evacuating the group home.</p> <p>On 7/26/13 at 8:10am, an interview with the QIDP was conducted. The QIDP indicated she had failed to report the weather related outage to BDDS. The QIDP indicated the event should have been reported because clients #1, #2, #3, and #4 were evacuated to a hotel for the night because of the loss of power. The QIDP provided a 7/25/13 BDDS report for an incident on 6/24/13 at 11:00pm. The QIDP stated "now it's late."</p> <p>On 7/26/13 at 8:10am, the 3/1/11 BDDS policy was reviewed and indicated "Reportable Incidents: Incidents to be reported to BDDS include any event or occurrence characterized by risk or uncertainty resulting in or having the</p>						

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	<p>potential to result in significant harm or injury to an individual including but not limited to...6. A service delivery site with a structural or environmental problem that jeopardizes or compromises the health or welfare of an individual."</p> <p>9-3-1(b)</p>			