

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 08/04/2014
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NAME OF PROVIDER OR SUPPLIER CORVILLA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 18443 BULLA RD SOUTH BEND, IN 46637
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(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
W000000	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: July 28, 29, 30, 31, and August 1 and 4, 2014.</p> <p>Facility number: 000740 Provider number: 15G214 AIM number: 100234800</p> <p>Surveyor: Tim Shebel, LSW</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed August 7, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000376	<p>483.460(k)(8) DRUG ADMINISTRATION The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician.</p> <p>Based on record review and interview, the facility failed to have evidence of immediately reporting a medication error to the physician for 1 of 3 additional clients (client #6).</p> <p>Findings include:</p>	W000376	<p>Clint #2, #4 and #7 will have all drugs and biologicals locked except when being prepared for administration All Corvilla consumers will have all drugs and biologicals locked except when being prepared for administration All Bulla Home staff (and staff in all of Corvillas homes) will be</p>	08/29/2014

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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W000382	<p>The facility's records were reviewed on 7/28/14 at 9:21 A.M. A review of incident reports from 7/1/13 to 7/28/14 indicated the following medication error:</p> <p>- While at camp on 6/3/14, camp staff administered another client's Risperdal (anti-psychotic medication) to client #6. The facility was notified of this incident.</p> <p>An "Appointment Record", dated 6/12/14, indicated client #6 had been seen by her physician in regard to the medication error. The review failed to indicate client #6's physician was immediately notified of the 6/3/14 medication error.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/31/14 at 11:07 A.M. QIDP #1 stated, "[Client #6's] was seen by her physician on 6/12/14 in regard to the med (6/3/14 medication) error."</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being</p>		<p>trained by 8-29-2014 to keep all drugs and biologicals locked except when being prepared for administration To ensure that all drugs and biologicals are kept locked except when being prepared for administration, the Nurse will monitor at weekly visits and Home Managers will monitor daily The above mentioned is effective immediately Completion 8-29-2014</p>				

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	<p>prepared for administration. Based on observation and interview, the facility failed to ensure medications were locked except when they were being prepared for administration for 2 of 4 sampled clients (clients #2 and #4) and 1 additional client (client #7).</p> <p>Findings include:</p> <p>Direct care staff #5 was observed passing medications during the 7/26/14 observation period from 6:40 A.M. until 8:15 A.M. At 6:58 A.M., direct care staff #5 prepared medications for client #7 as the client sat in a chair in the medication room. Direct care staff #5 left the medication room for 30 seconds with medications open on the counter while client #7 sat waiting for her medications. At 7:02 A.M., direct care staff #5 left the medication room for 22 seconds with medications open on the counter while client #4 sat waiting for her medications. At 7:27 A.M., direct care staff #5 left the medication room for 7 seconds with medications open on the counter while client #2 sat waiting for her medications.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/30/14 at 9:47 A.M. QIDP #1 stated, "Medications are to be locked when they aren't being administered or being</p>	W000382	To ensure all drugs and biological are locked except when being prepared; the Nurse will re-train all staff regarding drug storage and administration for clients #2, #4, and #7. The Nurse will also be responsible for monitoring drug storage and administration on a weekly visit. The Manager will be responsible for monitoring drug storage and administration daily. To ensure there are no other deficiencies of this nature occur in the future; the Nurse will be responsible for the monitoring of all homes weekly and the Manager(s) will be responsible for monitoring daily at each med pass. Thereby, ensuring all clients have all drugs and biological locked except when being prepared.	09/03/2014			

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	prepared to be administered." 9-3-6(a)				