

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	<p>This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00418430.</p> <p>Complaint #IN00418430: Federal and state deficiency related to the allegation(s) is cited at W149.</p> <p>Dates of Survey: 12/4, 12/5, 12/6, 12/7 and 12/8/23.</p> <p>Facility Number: 000891 Provider Number: 15G377 AIMS Number: 100244320</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #15068 on 12/21/23.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 3 of 3 sample clients (A, B and C), plus 4 additional clients (D, E, F and G), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the home was in good repair.</p> <p>Findings include:</p> <p>Observations were conducted on 12/4/23 from 3:39 pm to 6:00 pm and 12/5/23 from 5:58 am to 8:00</p>	W 0104	<p>Cleaning checklists are required to be completed by staff. The Managers will ensure they are completed by checking the items on the list when they work. They will submit the checklist weekly to the QIDP for review. When the QIDP or other administrators do home observations, they will also check to ensure the home is clean and free of any needed repairs. The bathrooms will be cleaned</p>	12/09/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Dan Peterson

DCCQA

01/17/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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>am. Clients A, B, D, E, F and G were present throughout the observation periods. Client C was on leave with his grandmother on 12/4/23 and not present in the home. The following environmental issues were noted affecting clients A, B, C, D, E, F and G:</p> <p>1. The overhead fan in client A's bedroom and in the dining room had a gray substance covering the fan blades.</p> <p>Staff #1 was interviewed on 12/4/23 at 5:48 pm. Staff #1 stated, "It is dust on the fan blades."</p> <p>2. The bathroom on the left side of the house had a black substance on the walls along the bottom of the shower.</p> <p>3. The gate to the fence leading to the back yard was broken and lying on the ground.</p> <p>4. Along the outside of the garage wall there were a broken desk and a truck bed toolbox.</p> <p>An interview with the Director of Corporate Compliance and Quality Assurance (DCCQA) was conducted on 12/7/23 at 12:11 pm. The DCCQA stated, "The home should be clean and things repaired as needed." The DCCQA indicated the fence was falling down the last time he had visited the home.</p> <p>An interview with the Chief Operations Officer (COO) was conducted on 12/7/23 at 2:16 pm. The COO stated, "The home should be well kept so staff and individuals have pride in where they work and live. It is not appropriate for desks and toolboxes to be sitting outside beside the garage."</p> <p>9-3-1(a)</p>		<p>daily and inspected by the managers each day they work and during observations by the QIDP and other administrators. All homes will be evaluated for repairs monthly by the maintenance director and by the safety committee quarterly, as well as the manager and QIDP weekly. All fencing outside will be repaired and checked regularly as stated above. Trash will not sit outside the homes; this will be checked during the above observations. All these things apply to all homes.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0129  Bldg. 00	<p>483.420(a)(7) <b>PROTECTION OF CLIENTS RIGHTS</b> The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy.</p> <p>Based on observation and interview for 1 of 3 sample clients (B) and 1 additional client (G), the facility failed to ensure clients B and G had window coverings in their bedroom to provide personal privacy.</p> <p>Findings include:</p> <p>Observations were conducted on 12/4/23 from 3:39 pm to 6:00 pm and 12/5/23 from 5:58 am to 8:00 am.</p> <p>Throughout the observation periods, the window covering on clients B and G's window did not have any blind or covering on the window.</p> <p>An interview with client B was conducted on 12/5/23 at 7:16 am. Client B stated, "My window has not had a blind on the window since I moved in. I would like to have a blind on my window."</p> <p>An interview with the Director of Corporate Compliance and Quality Assurance (DCCQA) was conducted on 12/7/23 at 12:11 pm. The DCCQA stated, "All windows should have blinds or curtains for privacy."</p> <p>An interview with the Chief Operations Officer (COO) was conducted on 12/7/23 at 2:16 pm. The COO stated, "Windows should all have coverings for privacy."</p> <p>9-3-2(a)</p>	W 0129	Window covering were purchased for this location and installed for privacy. All locations will also be checked during these observations by the managers, QIDP, and other administrators as well as the safety committee, to ensure window dressings are present in each room for privacy. The manager will do weekly observations which include checking the curtain s in each room to ensure privacy and document compliance on the observation form. This will occur at all homes. During random observations by the QIDP or other administrators, this same form will be used. The DCCQA will review all observation forms for compliance weekly.	12/09/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0149  Bldg. 00	<p>483.420(d)(1) <b>STAFF TREATMENT OF CLIENTS</b> 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 for 3 of 5 allegations of abuse and neglect reviewed, the facility failed to implement its policies and procedures to prevent 2 allegations of neglect for client A and 1 allegation of abuse for client C.</p> <p>Findings include.</p> <p>The facility's Bureau of Disabilities Services (BDS) reports and related investigations were reviewed on 12/4/23 at 2:42 pm.</p> <p>1. A BDS report dated 10/10/23 indicated the following: "An allegation was made regarding a staff using intimidation and comments making [client C] feel fearful. The staff was suspended pending investigation. ... Follow Up: 1. [Client C] was encouraged to share any feelings or concerns with staff or Corvilla management. [Client C] also has his grandmother to talk to as well as his counselor. 2. The allegation of emotional abuse was substantiated. The staff was found to be making comments to [client C] that made [client C] fearful in his home. The staff was terminated for emotional abuse. ...."</p> <p>An investigation dated 10/12/23 indicated the following, "...[Terminated staff] was emotionally abusive toward [client C] by creating fear in [client C] and making him fearful of his home, his housemate, and his safety. It is believed [terminated staff] did tell [client C] that his housemate would be in his bed one day and that his roommate had romantic feelings and was</p>	W 0149	Corvilla will continue to provide training on ANE upon hire and annually. In addition, Corvilla will require quarterly training on ANE and incident reporting to attempt to decrease the number of incidents. Corvilla will terminate staff for ANE as warranted. The manager, QIDP, and other administrators will observe staff to ensure there are no signs of ANE. Staff who also do not report suspicions will receive corrective action. During observations by administrators, persons served will be asked if anything abusive, neglectful or exploitative have occurred. All allegations will be investigated by the DCCQA.	01/07/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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>going to act on them one day. [Terminated staff] created emotional fear and pain in telling [client C] the story about the prisoners. [Terminated staff] also used intimidation in confronting [client C] about reporting this concern. [Terminated staff] was terminated for emotional abuse and intimidation. All staff did not communicate/document their concerns or observations."</p> <p>2. A BDS report dated 10/7/23 indicated the following:</p> <p>"It was reported to agency nurse on Sunday 10/8/23 around 11:00 am that [client A] had fallen out of bed Saturday during the night. [Client A] currently has a half side rail to help prevent him from falling. However, [client A] surpassed the rail and fell to the floor hitting his right temple. No bruising noted when assessed and neurological checks were started. Staff were able to get [client A] back into bed without issue. [Client A] appeared to be doing well on Sunday when (sic) nurse called the house and appears to be doing ok at day program today. Staff will resolve the neurological checks after the 72-hour mark. Staff will continue to monitor [client A] for any bruising that may appear or any abnormal behaviors. Any abnormal finding will be report to agency nurse."</p> <p>An investigation dated 10/9/23 indicated the following: "Conclusion: Staff did not follow Corvilla's policy on medical emergencies. Any suspected head, neck or back injury is considered life-threatening and 911 needs to be called. Training also indicated that the movement of the person should be minimized unless they are bleeding severely, in cardiac arrest, or the scene is unsafe. Staff did not follow this. 911 should have been called due to the fall and existing injuries from a fall 2 weeks prior. Staff also did not contact the nurse. Any falls require the nurse to be called</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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>immediately unless 911 needs to be contacted first and then 911 is called and then the nurse. Staff did begin neurological checks immediately."</p> <p>3. A BDS report dated 9/26/23 indicated the following:</p> <p>"On 9-26-23 at around 1:44 pm, at Corvilla's Connections Day Program, [Client A] had just been assisted with his toileting needs. The staff attached the sling back to the Hoyer to lift him up and put him back into his wheelchair. Staff lifted [client A] up using the Hoyer. When staff went to push the Hoyer toward [client A's] wheelchair, one of straps became unhooked and [client A] fell onto the floor landing on his head and side. The fall was about 4 feet. [Client A] was conscious the entire time. [Client A] is non-verbal. 911 was called and Emergency Medical Service (EMS) arrived and took [client A] to [hospital name]. A CT scan (x-ray scan) was done, the doctor believed there was a brain bleed. After a second CT test at around 8 pm, it was determined there was not a brain bleed. A chest x-ray did reveal a broken rib. [Client A] was sent home around 9 pm. The staff involved was suspended pending further investigation. [Client A] appears to be doing well. The staff was suspended pending further investigation. The Corvilla Nurse will contact the primary care physician (PCP) to request an additional CT scan to confirm there is not a brain bleed. Staff will conduct neurological checks for 72 hours. Staff will immediately report any changes in [client A's] condition."</p> <p>An investigation dated 9/28/23 indicated the following: "Conclusion: Staff did not immediately call 911 as they were trained. Any suspected or actual injury to someone's head, neck or back is considered life-threatening per American Red Cross training and Corvilla's Medical Emergencies</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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>Policy, which all staff receive upon hire and annually. A fall from this height would suggest the possibility of a head, neck, or back injury or multiple injuries. Staff should have contacted 911 first. Instead, two different staff came to the scene and then the nurse before 911 was called. ..."</p> <p>An interview with the Director of Corporate Compliance and Quality Assurance (DCCQA) was conducted on 12/7/23 at 12:11 pm. The DCCQA stated, "Staff should be following the Abuse, Neglect and Exploitation Policy. Staff did not follow the plan with incidents for [client A] and [client C]."</p> <p>An interview with the Chief Operations Officer (COO) was conducted on 12/7/23 at 2:16 pm. The COO stated, "Staff should always be following the Abuse, Neglect and Exploitation Policy."</p> <p>The facility Policy on Rights of Individuals Receiving Corvilla Services dated October 2023 was reviewed on 12/4/23 at 2:43 pm and indicated the following:</p> <p>"POLICY: It is Corvilla's policy to protect and promote the fundamental human rights of all persons receiving services from Corvilla. Rights of persons served shall not be violated and shall be protected under Corvilla administrative and personnel policies/procedures as well as applicable state and federal laws. ...PROCEDURE:</p> <p>I. Corvilla board, staff and volunteers shall not abuse, neglect, exploit or mistreat a person served or otherwise violate an individual's rights. ...III. Corvilla has developed policies and procedures that prohibit a. Abuse, neglect, or exploitation of an individual (Corvilla Policy on Incident Reporting Policy) b. Violation of an Individual's rights IV. Practices prohibited under this section include but are not limited to the following: ... c.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0159  Bldg. 00	<p>Emotional/verbal abuse, including but not limited to communication with works or actions in a person's presence with intent to: -Cause the individual to be placed in fear of retaliation. -Cause the individual to be placed in fear of confinement or restraint. -Cause the individual to experience emotional distress or humiliation. -Causes others to view the individual with hatred, contempt, disgrace, or ridicule.- Cause the individual to react in a negative manner. ...'Neglect' means failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual."</p> <p>This federal tag relates to complaint #IN00418430.</p> <p>9-3-2(a)</p> <p>483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- Based on record review and interview for 3 of 3 sampled clients (A, B and C), the Qualified Intellectual Disability Professional (QIDP) failed to effectively integrate, coordinate and monitor clients A, B and C's active treatment programs by not completing reviews of clients' goals.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 12/5/23 at 12:51 pm. Client A's Individual Support Plan (ISP) dated 12/28/22 indicated the following goals: "Medication, Dental Hygiene, Personal hygiene, Wardrobe maintenance, Toileting." The QIDP did not complete monthly reviews from August 2023 to November 2023.</p>	W 0159	<p>The QIDP will complete monthly reviews for each person served that includes progress on goals, activities completed that month, medical appointments, and any other pertinent information. As the QIDP's supervisor, the Residential Director will review these monthly to ensure completion. If the QIDP does not submit these by the designated due date of the 10th of the month, the Residential Director will give corrective action to the QIDP and ensure they are still completed by the QIDP or the Residential</p>	01/07/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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>2. Client B's record was reviewed on 12/5/23 at 2:25 pm. Client B's ISP dated 4/18/23 indicated the following goals: "Medication, Nutrition, Money management, Dental Hygiene, Personal hygiene, Community, Social." The QIDP did not complete monthly reviews from August 2023 to November 2023.</p> <p>3. Client C's record was reviewed on 12/6/23 at 11:09 am. Client C's ISP dated 5/16/23 indicated the following goals: "Medication, Dental Hygiene, Personal Hygiene, Domestic, Money Management, Exercise, Time management." The QIDP did not complete monthly reviews from August 2023 to November 2023.</p> <p>An interview with the Director of Corporate Compliance and Quality Assurance (DCCQA) was conducted on 12/7/23 at 12:11 pm. The DCCQA stated, "The Qualified Intellectual Disabilities Professional (QIDP) should be completing summaries monthly. The reports should include a summary of goals with percentages and how they are accomplishing their goals and if they should move on to the next step of the goal. The summaries should also include a summary of medical appointments and activities done that month."</p> <p>An interview with the Chief Operations Officer (COO) was conducted on 12/7/23 at 2:16 pm. The COO stated, "The QIDP should be completing summaries monthly that include all relevant data and any information that sheds light on progress or lack of progress on the goals that individuals are working on."</p> <p>9-3-3(a)</p>		Director is QIDP is no longer employed at Corvilla.	

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0210  Bldg. 00	<p>483.440(c)(3) <b>INDIVIDUAL PROGRAM PLAN</b> Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview for 1 of 3 sample clients (B), the facility failed to ensure client B had a Comprehensive Functional Assessment (CFA) completed within 30 days of admission.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 12/5/23 at 2:25 pm. Client B's record indicated an admission date of 4/29/23 and did not include a completed CFA.</p> <p>An interview with the Director of Corporate Compliance and Quality Assurance (DCCQA) was conducted on 12/7/23 at 12:11 pm. The DCCQA stated, "The CFA should be completed within 30 days of admission and then annually or if a condition changes."</p> <p>An interview with the Chief Operations Officer (COO) was conducted on 12/7/23 at 2:16 pm. The COO stated, "CFA should be completed within 30 days of admission, and then annually or if changes warrant an updated assessment."</p> <p>9-3-4(a)</p>	W 0210	<p>All CFA's will be completed 30 days after admission and annually or as needed if changes in level of functioning occur. The Residential Director will keep a tracking sheet of when annuals are due and ensure all annual information is completed by the QIDP. All homes were audited and any missing CFA's were completed. The person in question, Client B, has had their CFA completed. The Residential Director will track due dates of CFA's and review them annually or as needed for accuracy and compliance.</p>	01/07/2024
W 0331  Bldg. 00	<p>483.460(c) <b>NURSING SERVICES</b> The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and</p>	W 0331	All physician orders will be	01/07/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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>interview for 1 of 3 sampled clients (A), the facility's nursing services failed to obtain physician's orders for client A.</p> <p>Findings include:</p> <p>Observations were conducted on 12/4/23 from 3:39 pm to 6:00 pm. Client A was present in the home for the duration of the observation period.</p> <p>On 12/4/23 at 4:49 pm the house manager (HM) took client A to the medication room. Staff administered client A his medications of Diazepam 7 milligrams (mg) (used for seizure disorder), Baclofen 20 mg (used for cerebral Palsy), glycoprol 1 mg (used for preventative) and his feeding of Peptamen 1.5. Medications were administered through client A's gastrostomy Tube (G-tube).</p> <p>Client A's record was reviewed on 12/5/23 at 12:51 pm.</p> <p>Physician's orders were not available for review.</p> <p>An interview with the Registered Nurse (RN) was conducted on 12/8/23 at 12:40 pm. The RN stated, "I am working on getting physician's orders. We should have them annually."</p> <p>An interview with the Director of Corporate Compliance and Quality Assurance (DCCQA) was conducted on 12/7/23 at 12:11 pm. The DCCQA stated, "We should be getting physician's orders quarterly."</p> <p>An interview with the Chief Operations Officer (COO) was conducted on 12/7/23 at 2:16 pm. The COO stated, "We have not obtained physician's orders since [Dr. Name] retired last year.</p> <p>Physician's orders should be updated annually or</p>		<p>completed quarterly and reviewed by the nurse. A schedule of when they are to be completed will be sent to the Residential Director by the nurse. The Residential Director will ensure they are completed by the due date by reviewing the assessment. The nursing assessments have been completed for all persons served and sent to the physicians for review. The nurse will provide copies to the Residential Director, who supervises the nursing staff. The Residential Director will track the dates due, and dates completed for the assessments. The nurse is responsible for contacting and providing the doctors with the physician's orders.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0336  Bldg. 00	<p>as needed."</p> <p>9-3-6(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview for 3 of 3 sampled clients (A, B and C), the facility failed to ensure clients A, B and C's nursing quarterlies were available for review.</p> <p>Findings include:</p> <p>1) Client A's record was reviewed on 12/5/23 at 12:51 pm. The review indicated nursing quarterly reviews for October, November, and December 2022 (Quarter 4), January, February, and March 2023, April, May and June 2023 (Quarter 2) and July, August and September 2023 (Quarter 3) were not available for review.</p> <p>2) Client B's record was reviewed on 12/5/23 at 2:25 pm. The review indicated nursing quarterly reviews for October, November, and December 2022 (Quarter 4), January, February, and March 2023, April, May and June 2023 (Quarter 2) and July, August and September 2023 (Quarter 3) were not available for review.</p> <p>3) Client C's record was reviewed on 12/6/23 at 11:09 am. The review indicated nursing quarterly reviews for October, November, and December 2022 (Quarter 4), January, February, and March 2023, April, May and June 2023 (Quarter 2) and July, August and September 2023 (Quarter 3) were</p>	W 0336	<p>The Residential Director will ensure the nurse completes the nursing quarterlies as required. A schedule of when they are to be completed will be sent to the Residential Director by the nurse. The Residential Director will ensure they are completed by the due date by reviewing the assessment.</p>	01/07/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0440  Bldg. 00	<p>not available for review.</p> <p>There were no quarterly nursing assessments to review for clients A, B and C.</p> <p>An interview with the Registered Nurse (RN) was conducted on 12/8/23 at 12:40 pm. The RN stated, "I just started working at Corvilla part time. Nursing assessments should be completed quarterly for every client."</p> <p>An interview with the Director of Corporate Compliance and Quality Assurance (DCCQA) was conducted on 12/7/23 at 12:11 pm. The DCCQA stated, "The nurse should be doing assessments every month and quarter on all individuals."</p> <p>An interview with the Chief Operations Officer (COO) was conducted on 12/7/23 at 2:16 pm. The COO stated, "The nurse should be completing an assessment on clients every quarter."</p> <p>9-3-6(a)</p> <p>483.470(i)(1) <b>EVACUATION DRILLS</b> at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sample clients (A, B and C), plus 4 additional clients (D, E, F and G), the facility failed to conduct quarterly evacuation drills for each shift of personnel.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 12/5/23 at 1:41 pm for clients A, B, C, D, E, F and G and indicated the following:</p> <p>-During the day shift (7:00 am to 3:00 pm) the</p>	W 0440	Drills are tracked by the DCCQA. Each month, the DCCQA sends a report of non-completion to the manager, QIDP, and Residential Director. If not completed, the manager will receive corrective action. The DCCQA provides a schedule of when drills should be completed, and on which shift. If not completed by the 15th of each month, the manager, QIDP, and Residential Director will receive	01/02/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0488  Bldg. 00	<p>facility did not conduct evacuation drills from 1/9/23 to 5/19/23.</p> <p>-During the evening shift (3:00 pm to 11:00 pm) the facility did not conduct evacuation drills from 1/1/23 to 6/16/23 and 6/18/23 to 10/9/23</p> <p>-During the night shift (11:00 pm to 7:00 am) the facility did not conduct evacuation drills from 1/1/23 to 10/12/23.</p> <p>An interview with the Director of Corporate Compliance and Quality Assurance (DCCQA) was conducted on 12/7/23 at 12:11 pm. The DCCQA stated, "Drills should be done every month on a different shift each time."</p> <p>An interview with the Chief Operations Officer (COO) was conducted on 12/7/23 at 2:16 pm. The COO stated, "The evacuation drills should be done one per shift per quarter."</p> <p>9-3-7(a)</p> <p>483.480(d)(4) <b>DINING AREAS AND SERVICE</b> The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 2 of 3 sampled clients (clients B and C) plus 2 additional clients (F and G), the facility failed to ensure staff monitored clients B, C, F and G while eating.</p> <p>Findings include:</p> <p>Observations were conducted in the home on 12/5/23 from 5:58 am to 8:00 am. Clients B, C, F and G were present throughout the observations.</p>	W 0488	<p>notice that the drill has yet to be completed. All drills are reviewed and tracked by the DCCQA.</p> <p>Managers will observe staff daily when they work, to ensure staff are sitting with the persons served while they are eating and provide immediate correction if needed. The QIDP or other administrator will observe this behavior during random observations. Staff will be re-trained in this area. Staff who are observed to not follow dining plans or any risk plans will be</p>	12/08/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 12/08/2023
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 12/5/23 at 6:29 am client C was sitting at the dining room table eating. Client C finished his food and took his plate to the kitchen. Staff #2 and #3 were in the kitchen and not able to see client C eating. At 6:34 am client G sat at the dining room table and began eating his waffles with his fingers. Staff #3 was in the kitchen and unable to see client G eating. Client G finished his food at 6:37 am and took his plate to the kitchen. At 6:39 am client B went to the dining room table and ate his food. At 6:45 am client B finished eating and took his dishes to the kitchen. Staff were not in dining room while client B was eating. At 6:53 am client F sat in the dining room eating his waffles. At 6:58 am client F finished eating. Staff were not in the dining room while client F was eating.</p> <p>Throughout the observation clients were not being monitored while eating.</p> <p>An interview with staff #2 was conducted on 12/5/23 at 7:00 am. Staff #2 stated, "No one in the home has dietary restrictions so we don't have to watch them eat. Mornings, clients do their own thing, but at dinner we sit with them while they are eating."</p> <p>An interview with the Registered Nurse (RN) was conducted on 12/8/23 at 12:40 pm. The RN stated, "Staff are supposed to be sitting at the table when clients are eating. At least 1 staff should be at the table at all times."</p> <p>An interview with the Director of Corporate Compliance and Quality Assurance (DCCQA) was conducted on 12/7/23 at 12:11 pm. The DCCQA stated, "Staff should be sitting at the table eating with clients."</p>		subject to corrective action. A copy of each person's dining plan is located in the medication book for staff to review if they have any questions. Staff can also contact the manager, nurse, or QIDP with any questions.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2023
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 52549 MYRTLE ST SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	An interview with the Chief Operations Officer (COO) was conducted on 12/7/23 at 2:16 pm. The COO stated, "There should be a presence of staff throughout the meal regardless of assistance needed."  9-3-8(a)			