STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G377	A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	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	This visit was for a predetermined full recertification and state licensure survey. This visit included the COVID-19 focused infection control survey. Survey Dates: August 30, 31, and September 1, 2021. Facility Number: 000891 Provider Number: 15G377 AIMS Number: 100244320 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/17/21.	W 0000		
W 0149 Bldg. 00	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 for 2 of 3 sample clients (#1 and #2), plus 1 additional client (#4), the facility failed to implement its written policies and procedures to prevent falls for clients #1 and #2, abuse of client #2, elopement for client #2, and financial exploitation of client #4. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 8/30/21 at 3:30 pm.	W 0149	Corvilla will check for compliance in this area by having the QIDP, Residential Director and Compliance Director do random visits in the homes to ensure there is no sign of abuse, neglect, and exploitation. The QIDP and Corvilla nurse will review fall risk plans and elopement plans each quarter or if an incident occurs to ensure it is still practical. Staff will be retrained in any changes. During these random house visits, staff will be quizzed, and	09/30/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	1. A BDDS report dated 3/4/21 indicated the following: "On 2/3/21, during the morning routine at the group home, staff noted that [client #2] had fallen once that was unwitnessed and had fallen again with staff present on his way into the bathroom. Staff noted that [client #2] had lost his bowels when he fell the second time and it appeared that he was disoriented. Due to the falls and disorientation, [client #2] was sent out to the ER (emergency room) for further evaluation. While at the hospital a CT (computerized tomography) scan, labs, and urinalysis were ordered and completed. Labs and urinalysis came back within normal limits. CT scan showed a small pulmonary nodule. [Client #2] was then discharged back home with the following instructions: Follow up with primary care doctor within 1 week from hospital visit. [Client #2] can continue normal activity as tolerated." - The review did not include an investigation for client #2's unwitnessed fall. Client #2's record was reviewed on 8/31/21 at 11:11 am and did not include a high risk plan for falls. 2. A BDDS report dated 7/1/21 indicated the following: "On June 20, 2021, at around 1 pm, it was reported to the QIDP (Qualified Intellectual Disabilities Professional) for the group home, from one of the individuals living in the group home, that staff acted in an abusive/neglectful way toward [client #2] on 6/26/21, while on a trip to the [name of city]. The individual stated that [client #2] was left alone while at a mall and went missing. He was later found by staff. On the same day, this individual stated that staff 'dragged and pulled' [client #2] to get him out of another store and in		individuals fall and elopement plans. The QIDP, Residential Director and CCQA will talk to the individuals randomly to ensure their health and safety plans are being followed.	

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	getting him on the van. The QIDP notified Corvilla's Compliance Officer and an investigation began. The two staff in question were suspended immediately pending further investigation." An Investigation of Witnessed Abuse and Neglect dated 7/1/21 indicated the following: "Conclusion: Based on the individuals Corvilla serves, it is clear that [client #2] was abused. Both staff were physically aggressive with [client #2] based on the testimonies. Staff placed their hands on [client #2] and forced him to walk and forced him into the van. Both staff were emotionally abusive by refusing to let [client #2] buy something and using that as a 'punishment' for leaving the group earlier in the day. Aversive techniques such as punishment violate Corvilla's policy and violates the individuals' rights. Both staff were also neglectful. They left [client #2] alone and out of visual contact. It appears [client #2] was missing for 10 - 30 minutes. [Client #2] has eloped in the past. [Client #2] has a risk plan stating he cannot be left unsupervised. [DSPS #3 and #4] both admitted to holding onto [client #2] and walking along beside him. Both staff admitted that [client #2] did not purchase anything at the candy store and everyone else did. Both staff admitted to leaving [client #2] sitting alone outside the store while they shopped in the store. There was a general impression from the individuals living in the home that this treatment is ok since [client #2] was refusing to do things a feeling of, they were getting staff in trouble and really, it is [client #2's] fault. Therefore, both staff were terminated for substantial abuse and neglect. Recommendations: 1) All the individuals living in the home, will be			

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	offered training in abuse, neglect, and exploitation. 2) All the individuals living in the home, will be offered training in client rights and that it is everyone is (sic) right to be free from abuse, neglect, and exploitation no matter what they do. 3) Due to substantiation of abuse and neglect, both staff were terminated. 4) Staff meeting for the home to be clear on appropriate ways to work with the individuals served." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "They went to [name of city] the previous weekend. 5 of the individuals and 2 staff. Another client reported to the previous QIDP, while they were there, [client #2] left the group. Staff had to pick him up and put him in the van. We did an investigation. We talked to the other individuals. He was gone at least 20 minutes. The staff went into the store. He didn't want to go. They left him alone, and he left. He was gone about 20 minutes. When they tried to get him to leave, he sat down. Staff picked him up and put him in the van. One staff admitted to the physical part. They both admitted to leaving him alone." 3. A BDDS report dated 8/13/21 indicated the following: "On 8/12/21, [client #2] went to [name of city] to attend a baseball game at [name of stadium]. At approximately 5:30 pm, SGL staff reported to QIDP that [client #2] requested to use the restroom. The male SGL (supported group living) staff assisted [client #2] to the bathroom which involved using a bathroom stall. The staff also used the restroom at this time. SGL staff finished up in the restroom and waited outside the			

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	bathroom for [client #2] to finish up. After approximately 2 minutes, staff entered bathroom once again and realized that [client #2] had left. SGL staff immediately notified [stadium] staff and [client #2] was found within 10 minutes of him eloping. [Client #2] was unharmed and went back to his seat with SGL staff." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "They went to a [baseball team's] game 3 weeks ago. [Client #2] went to the bathroom. He and staff went into separate stalls. [Client #2] had already left when staff came out. The [baseball stadium] staff found him within 5-10 minutes." 4. A BDDS report dated 8/25/21 indicated the following: "At approximately 6:00 pm SGL (supported group living) manager informed QIDP (Qualified Intellectual Disabilities Professional) that [client #2] had eloped. While SGL manager was attending to another resident, two other SGL staff were outside of the residence with [client #2]. Both SGL staff went to pick up another resident from work while [client #2] was still at the residence. As the two SGL staff left and SGL manager was attending to another individual, [client #2] had eloped without the manager's knowledge. [Client #2] was gone for 10 minutes and returned to the house stating that he needed a break." An Investigation of Elopement Incident dated 8/25/21 indicated the following: "Conclusion: The incident could have been avoided had [DSP #5] followed [House Manager (HM) #1's] instructions or communicated a change in plans. [HM #1] informed [DSP #5] that			

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	he needs to communicate changes before doing them." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "There were 3 staff at the house. One went to pick up [client #4] from work. The other 2 staff were staying behind. [HM #1] was taking care of [client #1]. [DSP #5] decided to ride along and didn't tell the manager. [Client #2] walked out the door while the manager was with [client #1]. Another staff was coming home with another client from an outing and saw [client #2] walking down the street alone." Client #2's record was reviewed on 8/31/21 at 11:11 am. Client #2's Behavior Support Plan (BSP) dated 8/12/21 indicated the following: "Target Behaviors: Elopement - [Client #2] has a history of leaving the home, day program, and community activities.... Proactive Intervention Strategies: Elopement - Environmental triggers include going to events, going to day program, visiting with his family. - Antecedents include anxiety when others begin to leave, when [client #2] knows the event is over, when staff tell [client #2] it is time to go. - Praise [client #2] for handling the situation before target behaviors are exhibited.... Maladaptive Behavior Reduction Elopement - [Client #2] will be reminded that the preferred activity will occur again. - [Client #2] should have a calendar showing all of his outings including day program, so that he can see that his preferred activity will occur again. - [Client #2] should be reminded that his brother wants to know anytime he exhibits these			

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	behaviors; [client #2] will generally not want his brother to know this and will stop the activity. - Talk to [client #2]; many times he is upset and a solution can be reached. - Staff will ask [client #2] what he wants to do when he gets to his next destination such as home. - Staff may have to wait him (sic) and continue to talk to him and look for solutions. - Staff should be conscious when the door alarm goes off and make sure they know where [client #2] is." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "We do investigate elopements. The investigation does not include a review of the BSP. The purpose of the investigation is to see where staff was and determine what we can do to prevent it in the future." 5. A BDDS report dated 5/28/21 indicated the following: "On 5/28/21, it was reported that staff found [client #1] on the floor face first. It appeared [client #1] had fallen out of bed. Staff followed [client #1's] fall risk plan and followed through with what was expected. Due to [client #1] having an unwitnessed fall, being non-verbal, and unable to express his pain, he was sent out to the ER (emergency room) via ambulance to be further evaluated. At the hospital, x-rays and labs were ordered and completed. No abnormal findings. [Client #1] was then discharged back to group home with the following instructions; follow up with primary care doctor within 5 - 7 days of ER visit. [Client #1] returned home and appears to be in a good mood." - The review did not include an investigation for			

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	client #1's fall. Client #1's record was reviewed on 8/31/21 at 9:57 am. Client #1's high risk plan for falls dated 6/21 indicated the following: "3. Staff guidelines: g. Staff to always make sure half rail is in place when [client #1] is in bed." 6. A BDDS report dated 7/7/21 indicated the following: "It was discovered on 7/6/21, that $148 was missing from [client #4's] financial account at the group home. An investigation immediately began. [Client #4] was interviewed and stated he did not have access to the money after his trip on 6/27/21. He asked to use it on 7/6/21, and it was discovered to be missing. All staff were interviewed and only two staff knew that it was there and where it was located. Those two staff were suspended and later terminated for abuse and neglect stemming from an incident reported on 6/30/21. [Direct Support Professional (DSP) #3], one of the terminated staff, did respond and stated she left the money in [client #4's] med (medication) drawer, and it totaled $148.58. Only $.58 was found and some receipts from his trip in June. [DSP #3] stated [DSP #4], who was terminated from the 6/30/21 incident, knew the money was there on 6/30/21. When they were both suspended that day for the 6/30/21 incident, [DSP #3] said she left the home immediately, but [DSP #4] was still in the home gathering her personal belongings because she felt she was going to be terminated. [DSP #4] refused to return any phone calls on 7/6/21. It is believed, after investigating, one of these two staff may have taken the money since they knew where it was located and were the last to see the money as best			

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	as we can determine, but Corvilla cannot say for certain. Both staff have already been terminated for the 6/30/21 incident. Plan to Resolve: Corvilla reimbursed the $148 to [client #4] on 7/6/21. All managers and staff will be retrained on counting the money on hand each shift as required by Corvilla policy and keeping the money secured in the appropriate place." An Investigation of Exploitation dated 7/7/21 indicated the following: "Conclusion: It is believed, after investigating, one of these two staff [DSPs #3 and #4] may have taken the money, since they knew where it was located and were the last to see the money as best as we can determine, but Corvilla cannot say for certain. Both staff have already been terminated for an incident of abuse and neglect that stemmed from 6/30/21. Corvilla reimbursed the $148 to [client #4] on 7/6/21. Recommendations: All managers and staff will be retrained on counting the money on hand each shift as required by Corvilla policy and keeping the money secured in the appropriate place." CCQAD #1 was interviewed on 8/31/21 at 1:00 pm and stated, "We tell the managers, anytime they take money (out of the clients' bank accounts) it needs to be spent that day. If not, it needs to be put back in the bank. Anything over $50 needs to be put back in the bank." CCQAD #1 stated, "The manager should count the money daily or every shift they work. Everyone is supposed to have access to their petty cash." The facility's Incident Reporting and Management Policy dated August 2018 was reviewed on			

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	8/31/21 at 2:00 pm and indicated the following: "It is the policy of Corvilla, Inc. to: - Ensure the health and safety of all its clients. - Regard a reportable incident as any event or occurrence characterized by risk or uncertainty, resulting in or having the potential to result in significant harm or injury to an individual or death of an individual. - Not tolerate abuse, neglect, or exploitation of clients by staff members, clients, or persons in the community. - Maintain and train its staff as well as implement all current state agency/authority incident reporting requirements. - Protect the confidentiality of all persons involved in an investigation. - Continually assess the agency's internal investigation system and make adjustments as needed to improve its effectiveness. I. Definition of Reportable Incidents Reportable incidents include but are not limited to: 1. Alleged, suspected, or actual abuse, (which must also be reported to Adult Protective Services (APS) or Child Protective Services (CPS) as indicated) which includes but is not limited to: a. physical abuse, including but not limited to: i. intentionally touching another person in a rude, insolent or angry manner; ii. willful infliction of injury; iii. unauthorized restraint or confinement resulting from physical or chemical intervention; iv. rape;.... 2. Alleged, suspected, or actual neglect (which must also be reported to [APS] or [CPS] as indicated) which includes but is not limited to: a. failure to provide appropriate supervision, care, or training;... 3. Alleged, suspected, or actual exploitation (which must also be reported to [APS] or [CPS] as			

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	indicated) which includes but is not limited to: a. unauthorized use of the:... ii. personal property or finances; or.... 8. Elopement of an individual that results in evasion of required supervision as described in the ISP as necessary for the individuals health and welfare.... 15. A fall resulting in injury, regardless of the severity of the injury.... III. Investigations of Allegations (Internal): When action by a Corvilla employee or client are alleged to be abusive, neglectful, or exploitative or to involve criminal activity, the Human Right Officer, hereafter called the investigator, will within 48 hours after the receipt of the verbal report or such other time frame as may be determined appropriate, conduct an investigation and complete a written investigation report. A. The investigation will include the following procedures: 1.) an interview with the reporting staff member. 2.) An interview with any other witnesses including clients. 3.) An interview with the client in the presence of his or her program manager. 4.) An interview with the accused. 5.) Every attempt will be made to conduct interviews in the primary language of the individual being interviewed. B. The report shall include: 1.) A statement of the incident. 2.) A statement regarding information gained from interviews. 3.) findings of substantiation or unsubstantiation of allegation(s), and intent. 4.) Input into a recommendation for resolution. Disciplinary action, if warranted will be determined by the division management staff in conjunction with the Chief Human Resources Officer.			

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	5.) An assessment of the agency incident reporting and investigation process.... B. If abuse, neglect, or financial exploitation has occurred, sanction may be invoked by the Management Staff in conjunction with the Chief Human Resources Officer. The accused, the reporting staff member, the client, the guardian, the CEO (Chief Executive Officer), and Chief Human Resources Officer are notified that allegation has been substantiated and appropriate action has been taken. The confidentiality of all involved parties shall be maintained in the resolution. When sanction of written warning, suspension, or dismissal has been invoked, it shall be recorded in the employee's personnel file with his or her knowledge and any written statement he or she may care to submit." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "Staff report allegations of abuse and neglect to me. They can also call the residential director or the QIDP. I submit a report to BDDS within 24 hours of knowledge. Investigations are completed within 5 days. Staff are suspended immediately as well until the investigation is over." 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 4 of 25 allegations of abuse, neglect, and exploitation reviewed, the facility failed to thoroughly investigate falls for clients #1 and #2 and elopements for client #2.	W 0154	1.All falls regardless if they are medically related will W_0157be investigated regardless on the condition of the fall. Anyone that falls will be given a fall risk plan. A risk plan has been developed for	10/20/2021

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	Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 8/30/21 at 3:30 pm. 1. A BDDS report dated 3/4/21 indicated the following: "On 2/3/21, during the morning routine at the group home, staff noted that [client #2] had fallen once that was unwitnessed and had fallen again with staff present on his way into the bathroom. Staff noted that [client #2] had lost his bowels when he fell the second time and it appeared that he was disoriented. Due to the falls and disorientation, [client #2] was sent out to the ER (emergency room) for further evaluation. While at the hospital a CT (computerized tomography) scan, labs, and urinalysis were ordered and completed. Labs and urinalysis came back within normal limits. CT scan showed a small pulmonary nodule. [Client #2] was then discharged back home with the following instructions: Follow up with primary care doctor within 1 week from hospital visit. [Client #2] can continue normal activity as tolerated." - The review did not include an investigation for client #2's unwitnessed fall. 2. A BDDS report dated 8/13/21 indicated the following: "On 8/12/21, [client #2] went to [name of city] to attend a baseball game at [name of stadium]. At approximately 5:30 pm, SGL (supported group living) staff reported to QIDP (Qualified Intellectual Disabilities Professional) that [client #2] requested to use the restroom. The male SGL staff assisted [client #2] to the bathroom which		client #2, effective 9/29/2021. Staff will be train on FRP on 9/30/21 All investigations will be completed by the Quality Assurance Director. The QAD will be in contact with the QIDP with findings. Before filing a state report, the Director of Residential Services will audit the investigation to ensure that the investigation is thorough - if the director is not available, the Director of Operations can also audit the investigation for quality before a state report is completed. All reports will be completed within 24 hours of knowledge. 2.For someone that elopes, an investigation will be completed and the behavior support plan will be reviewed and revised if necessary as each elopement incident occurs. Staff were retrained on the behavior support plans effective 9/30/21. Elopements will be reported by DSP immediately. A thorough investigation will be completed. All investigations will be completed by the Quality Assurance Director. The QAD will be in contact with the QIDP with findings. Before filing a state report for elopements, the Director of Residential Services will audit the investigation to ensure that the investigation is thorough - if the director is not available, the Director of Operations can also audit the investigation for quality before a state report is completed.	

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	15G377	A. BUILDING 00 B. WING	09/01/2021

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	involved using a bathroom stall. The staff also used the restroom at this time. SGL staff finished up in the restroom and waited outside the bathroom for [client #2] to finish up. After approximately 2 minutes, staff entered bathroom once again and realized that [client #2] had left. SGL staff immediately notified [stadium] staff and [client #2] was found within 10 minutes of him eloping. [Client #2] was unharmed and went back to his seat with SGL staff." - The review did not include an investigation. Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "They went to a [baseball team's] game 3 weeks ago. [Client #2] went to the bathroom. He and staff went into separate stalls. [Client #2] had already left when staff came out. The [baseball stadium] staff found him within 5-10 minutes." 3. A BDDS report dated 8/25/21 indicated the following: "At approximately 6:00 pm SGL (supported group living) manager informed QIDP (Qualified Intellectual Disabilities Professional) that [client #2] had eloped. While SGL manager was attending to another resident, two other SGL staff were outside of the residence with [client #2]. Both SGL staff went to pick up another resident from work while [client #2] was still at the residence. As the two SGL staff left and SGL manager was attending to another individual, [client #2] had eloped without the manager's knowledge. [Client #2] was gone for 10 minutes and returned to the house stating that he needed a break." An Investigation of Elopement Incident dated 8/25/21 indicated the following:		All reports will be completed within 24 hours of knowledge. If an elopement occurs, the QIDP will look at the behavior support plan and revise if necessary to better suit the individual. 3.For someone that elopes, an investigation will be completed and the behavior support plan will be reviewed and revised if necessary as each elopement incident occurs. Staff will be retrained on behavior support plan effective 9/30/21. This practice will apply to all homes.	

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	"Conclusion: The incident could have been avoided had [DSP #5] followed [House Manager (HM) #1's] instructions or communicated a change in plans. [HM #1] informed [DSP #5] that he needs to communicate changes before doing them." - The investigation did not include a review of client #2's BSP or corrective action. CCQAD #1 was interviewed on 8/31/21 at 1:00 pm and stated, "There were 3 staff at the house. One went to pick up [client #4] from work. The other 2 staff were staying behind. [HM #1] was taking care of [client #1]. [DSP #5] decided to ride along and didn't tell the manager. [Client #2] walked out the door while the manager was with [client #1]. Another staff was coming home with another client from an outing and saw [client #2] walking down the street alone." CCQAD #1 stated, "We do investigate elopements. The investigation does not include a review of the BSP. The purpose of the investigation is to see where staff was and determine what we can do to prevent it in the future." 4. A BDDS report dated 5/28/21 indicated the following: "On 5/28/21, it was reported that staff found [client #1] on the floor face first. It appeared [client #1] had fallen out of bed. Staff followed [client #1's] fall risk plan and followed through with what was expected. Due to [client #1] having an unwitnessed fall, being non-verbal, and unable to express his pain, he was sent out to the ER (emergency room) via ambulance to be further evaluated. At the hospital, x-rays and labs were ordered and completed. No abnormal findings. [Client #1] was then discharged back to group home with the following instructions; follow up with primary care doctor within 5 - 7 days of ER			

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	visit. [Client #1] returned home and appears to be in a good mood." - The review did not include an investigation for client #1's fall. CCQAD #1 was interviewed on 8/31/21 at 1:00 pm and stated, "We do investigate unwitnessed falls. We talk to the staff to see what happened and if there are ways to prevent that. I thought we did investigations. I know we talked to the staff. Maybe we didn't type anything up." 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 3 of 25 allegations of abuse, neglect, and exploitation reviewed, the facility failed to effectively implement corrective action to prevent elopement for client #2. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 8/30/21 at 3:30 pm. 1. A BDDS report dated 7/1/21 indicated the following: "On June 20, 2021, at around 1 pm, it was reported to the QIDP (Qualified Intellectual Disabilities Professional) for the group home, from one of the individuals living in the group home, that staff acted in an abusive/neglectful way toward [client #2] on 6/26/21, while on a trip to the [name of city]. The individual stated that [client #2] was	W 0157	Once the investigation is completed by the CCQA Director and findings are reported to the appropriate Director and what action is needed, the CCQA Director will notify the Human Resources Director to let them know of pending corrective action. Human Resources will contact the CCQA Director to inform when corrective action is received and the CCQA Director will track corrective actions for compliance. Corvilla's CCQA Director follows the policy regarding investigations. All persons involved are interviewed as well as any witnesses and anyone else who may be able to give information about the issue. All appropriate records are reviewed and evaluated for any needed	09/30/2021

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	left alone while at a mall and went missing. He was later found by staff. On the same day, this individual stated that staff 'dragged and pulled' [client #2] to get him out of another store and in getting him on the van. The QIDP notified Corvilla's Compliance Officer and an investigation began. The two staff in question were suspended immediately pending further investigation." An Investigation of Witnessed Abuse and Neglect dated 7/1/21 indicated the following: "Conclusion: Based on the individuals Corvilla serves, it is clear that [client #2] was abused. Both staff were physically aggressive with [client #2] based on the testimonies. Staff placed their hands on [client #2] and forced him to walk and forced him into the van. Both staff were emotionally abusive by refusing to let [client #2] buy something and using that as a 'punishment' for leaving the group earlier in the day. Aversive techniques such as punishment violate Corvilla's policy and violates the individuals' rights. Both staff were also neglectful. They left [client #2] alone and out of visual contact. It appears [client #2] was missing for 10 - 30 minutes. [Client #2] has eloped in the past. [Client #2] has a risk plan stating he cannot be left unsupervised. [DSPS #3 and #4] both admitted to holding onto [client #2] and walking along beside him. Both staff admitted that [client #2] did not purchase anything at the candy store and everyone else did. Both staff admitted to leaving [client #2] sitting alone outside the store while they shopped in the store. There was a general impression from the individuals living in the home that this treatment is ok since [client #2] was refusing to do things a feeling of, they were getting staff in trouble and really, it is [client #2's] fault. Therefore, both staff were terminated for		changes. The CEO/COO are given a copy of the investigation to review.	

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	substantial abuse and neglect. Recommendations: 1) All the individuals living in the home, will be offered training in abuse, neglect, and exploitation. 2) All the individuals living in the home, will be offered training in client rights and that it is everyone is (sic) right to be free from abuse, neglect, and exploitation no matter what they do. 3) Due to substantiation of abuse and neglect, both staff were terminated. 4) Staff meeting for the home to be clear on appropriate ways to work with the individuals served." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "They went to [name of city] the previous weekend. 5 of the individuals and 2 staff. Another client reported to the previous QIDP, while they were there, [client #2] left the group. Staff had to pick him up and put him in the van. We did an investigation. We talked to the other individuals. He was gone at least 20 minutes. The staff went into the store. He didn't want to go. They left him alone, and he left. He was gone about 20 minutes. When they tried to get him to leave, he sat down. Staff picked him up and put him in the van. One staff admitted to the physical part. They both admitted to leaving him alone." 2. A BDDS report dated 8/13/21 indicated the following: "On 8/12/21, [client #2] went to [name of city] to attend a baseball game at [name of stadium]. At approximately 5:30 pm, SGL (supported group living) staff reported to QIDP that [client #2] requested to use the restroom. The male SGL staff			

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	assisted [client #2] to the bathroom which involved using a bathroom stall. The staff also used the restroom at this time. SGL staff finished up in the restroom and waited outside the bathroom for [client #2] to finish up. After approximately 2 minutes, staff entered bathroom once again and realized that [client #2] had left. SGL staff immediately notified [stadium] staff and [client #2] was found within 10 minutes of him eloping. [Client #2] was unharmed and went back to his seat with SGL staff." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "They went to a [baseball team's] game 3 weeks ago. [Client #2] went to the bathroom. He and staff went into separate stalls. [Client #2] had already left when staff came out. The [baseball stadium] staff found him within 5-10 minutes." 3. A BDDS report dated 8/25/21 indicated the following: "At approximately 6:00 pm SGL (supported group living) manager informed QIDP (Qualified Intellectual Disabilities Professional) that [client #2] had eloped. While SGL manager was attending to another resident, two other SGL staff were outside of the residence with [client #2]. Both SGL staff went to pick up another resident from work while [client #2] was still at the residence. As the two SGL staff left and SGL manager was attending to another individual, [client #2] had eloped without the manager's knowledge. [Client #2] was gone for 10 minutes and returned to the house stating that he needed a break." An Investigation of Elopement Incident dated 8/25/21 indicated the following:			

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	"Conclusion: The incident could have been avoided had [DSP #5] followed [House Manager (HM) #1's] instructions or communicated a change in plans. [HM #1] informed [DSP #5] that he needs to communicate changes before doing them." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "There were 3 staff at the house. One went to pick up [client #4] from work. The other 2 staff were staying behind. [HM #1] was taking care of [client #1]. [DSP #5] decided to ride along and didn't tell the manager. [Client #2] walked out the door while the manager was with [client #1]. Another staff was coming home with another client from an outing and saw [client #2] walking down the street alone." Client #2's record was reviewed on 8/31/21 at 11:11 am. Client #2's Behavior Support Plan (BSP) dated 8/12/21 indicated the following: "Target Behaviors: Elopement - [Client #2] has a history of leaving the home, day program, and community activities.... Proactive Intervention Strategies: Elopement - Environmental triggers include going to events, going to day program, visiting with his family. - Antecedents include anxiety when others begin to leave, when [client #2] knows the event is over, when staff tell [client #2] it is time to go. - Praise [client #2] for handling the situation before target behaviors are exhibited.... Maladaptive Behavior Reduction Elopement - [Client #2] will be reminded that the preferred activity will occur again. - [Client #2] should have a calendar showing all of			

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	his outings including day program, so that he can see that his preferred activity will occur again. - [Client #2] should be reminded that his brother wants to know anytime he exhibits these behaviors; [client #2] will generally not want his brother to know this and will stop the activity. - Talk to [client #2]; many times he is upset and a solution can be reached. - Staff will ask [client #2] what he wants to do when he gets to his next destination such as home. - Staff may have to wait him (sic) and continue to talk to him and look for solutions. - Staff should be conscience when the door alarm goes off and make sure they know where [client #2] is." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "We do investigate elopements. The investigation does not include a review of the BSP. The purpose of the investigation is to see where staff was and determine what we can do to prevent it in the future." 9-3-2(a)			
W 0159 Bldg. 00	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 sample clients (#1, #2, and #3), the Qualified Intellectual Disabilities Professional failed to effectively coordinate, integrate, and monitor clients #1, #2, and #3's active treatment programs.	W 0159	The Residential Director will review all active treatment schedules before they are implemented. The residential director will ensure the QIDP completes the treatment	09/30/2021

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	The QIDP failed to ensure clients #1, #2, and #3 had Comprehensive Functional Assessments (CFAs) completed within 30 days of admission, to develop Individual Service Plans (ISPs) for clients #1 and #2 within 30 days of admission, to ensure clients #1, #2, and #3's active treatment programs and plans were implemented during formal and informal training opportunities, to develop active treatment schedules for clients #1, #2, and #3, and to ensure client #3's goals were implemented and recorded as indicated in his ISP. Findings include: 1. Client #3's record was reviewed on 8/31/21 at 11:26 am and did not include reviews of goal progress by the QIDP. QIDP #1 was interviewed on 8/31/21 at 12:50 pm and stated, "We don't have reviews. It should be done monthly." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "The QIDP oversees the home and provides training to the staff. They oversee the individuals and makes sure their needs are met. The QIDP writes the ISP, the CFA, and the BSP." 2. The QIDP failed to ensure clients #1, #2, and #3 had CFAs completed within 30 days of admission. Please see W210. 3. The QIDP failed to ensure clients #1 and #2 had ISPs developed within 30 days of admission. Please see W226. 4. The QIDP failed to ensure clients #1, #2, and #3's active treatment programs and plans were		schedules within 30 days of a new residence and yearly thereafter. The Residential Director will keep a tracking sheet when items are due and document completion. The QIDP will implement the active treatment schedules and will coordinate these with house manager. Copies of the active treatment schedules will be left in home to ensure that all staff have access to the schedule. QIDP will monitor active treatment schedule by completing visits in home on all shifts that individuals are awake. QIDP will complete a visitation form and a summary of what the QIDP witnessed while at the location. These will be turned into the Residential Director weekly. QIDP will visit house at least 1 time per week. No clients were affected by this deficient practice. All individuals are active within the home and typically socialize with the staff throughout the evening. All individuals are being interacted with at least every 20 minutes. The residential director will ensure that the QIDP is integrating the active treatment schedules by completing house visits at least 1x per month. They will complete a visit sheet and will discuss their findings with QIDP at least 1x per month. Frequent communication will occur between QIDP and Residential Director and	

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	implemented during formal and informal training opportunities. Please see W249. 5. The QIDP failed to develop active treatment schedules for clients #1, #2, and #3. Please see W250. 6. The QIDP failed to ensure client #3's goals were implemented and recorded as indicated in his ISP. Please see W252. 9-3-3(a)		Residential Director will review the weekly visit forms that the QIDP turns into them.	
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation and interview for 3 of 3 sample clients (#1, #2, and #3), plus 4 additional clients (#4, #5, #6, and #7), the facility failed to provide sufficient direct care staff to address clients #1, #2, #3, #4, #5, #6, and #7's needs. Findings include: Observations were conducted in the group home on 8/30/21 from 4:00 pm through 5:30 pm with clients #1, #2, #3, #5, #6, and #7 present throughout the observation period, and on 8/31/21 from 6:00 am through 8:15 am with clients #1, #2, #3, #4, #5, #6, and #7 present throughout the observation period.	W 0186	Corvilla will ensure that the group has adequate staffing. If an employee does call off, a second staff member will come in to assist with any shift. Corvilla does implement an on call system in which the manager will be notified of a call off and will find coverage for the shift. If needed, we will move trained staff from site to site to provide adequate staffing. House managers will complete a weekly house schedule with all needed shifts filled. The QIDP and Residential Director will observe these schedules weekly. They will	10/20/2021

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	On 8/30/21 at 4:00 pm, clients #1, #2, #3, #5, #6, and #7 arrived to the home with Direct Support Professional (DSP) #1. Maintenance worker #1 was already in the home. Clients #2, #3, #4, #6, and #7 got off the bus and went into the home. DSP #1 used a wheelchair lift to assist client #1 off of the bus. DSP #1 took client #1 into the home. When the surveyor went to the front door, client #7 greeted the surveyor. Client #7 stated, "[DSP #1] is our staff tonight. You can come in." Client #1 was in the living room, and maintenance worker #1 turned on the television for him. Maintenance worker #1 went outside and sat on the front porch with client #2. At 4:03 pm, DSP #1 stated, "One staff is out of town, and the other is on overnight." DSP #1 went into the medication room and shut the door. Client #1 was in the living room watching television. Client #2 was outside with the maintenance staff. Clients #3, #4, #6, and #7 were in their bedrooms. While DSP #1 prepared client #5's medications, the alarm on the front door chimed 3 times. DSP #1 did not leave the medication room to see why the door was being opened. At 4:10 pm, DSP #1 left client #5's medication on a desk in the medication room and went to call client #5. DSP #1 stated, "I usually do [client #5's] first because he has the most. I save [client #1] for last. His have to be crushed up, and I have to feed him." At 4:16 pm, DSP #1 was in the medication room passing medications with the door closed. Client #1 was in the living room watching television. Client #7 was putting paper plates on the dining table. Client #7 stated, "I'm helping set the table." Client #7 stated, "[Client #3] is in his bedroom. [Client #6] is in his bedroom. [Client #5] is right there in the kitchen. [Client #1] is watching tv.		be turned in on the Friday before the next week. These will be approved by the QIDP. If any changes occur, the QIDP will be notified by the house manager. If the shift is affected by a call off, the house manager will find coverage or will cover the shift themselves. If they are unable, the QIDP will be called for assistance. At this time QIDP can pull staff from another house or come in to work at the house.	

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	[Client #2] is outside. [Client #4] is at work. He'll be here after 6." At 4:29 pm, DSP #1 brought client #1 into the medication room and gave him his medications and evening meal. At 4:45 pm, the door alarm chimed two times. DSP #1 stated, "Who is coming in and out?" DSP #1 did not open the door to see why the door was being opened. At 4:50 pm, DSP #1 took client #1 out of the medication room. DSP #1 left the medication cabinet unlocked. At 4:51 pm, clients #2, #5, #6, and #7 were in the kitchen looking at pizza boxes on the counter. Client #7 indicated the pizza had been delivered while DSP #1 was passing medications. DSP #1 prompted the clients to wash their hands and help themselves. DSP #1 prompted client #3 to come out of his room for dinner, but he refused. At 4:54 pm, DSP #1 brought client #1 from the living room to the kitchen. Client #1 sat in his wheelchair and watched clients #2, #5, #6, and #7 eat pizza and breadsticks. At 5:06 pm, client #3 came out of his bedroom and stated, "Is there any left for me?" Client #3 put two slices of pizza on a plate and ate while standing in the kitchen. At 5:14 pm, client #2 asked DSP #1 a question. DSP #1 stated, "I can't take you for a walk today because I have to watch everybody. Maybe we can go tomorrow." DSP #1 was interviewed on 8/30/21 at 5:22 pm and stated, "We usually have enough staff to do everything. [Client #1] should not be left alone. The rest are self sufficient. [Client #2] gets a little			

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	excited. He's going through dementia." On 8/31/21 at 6:00 am, the surveyor was greeted at the door by DSP #2. DSP #2 stated, "I'll be passing medications while [House Manager (HM) #1] helps [client #1]." From 6:03 am until 6:31 am, HM #1 was in client #1's bedroom assisting him with toileting and dressing tasks. DSP #2 was in the medication room with the door shut from 6:03 am until 7:15 am. At 6:45 am, clients #2, #5, and #7 were in the kitchen. Client #7 opened the freezer door and took out a box of frozen breakfast sandwiches. Client #7 handed a breakfast sandwich to clients #2 and #5. Clients #2, #5, and #7 each took turns warming their sandwiches in the microwave then sat down to eat at the table. Client #1 was sitting in the living room in front of the television. Clients #3, #4, and #6 were in their bedrooms. At 7:00 am, clients #1, #4, #6, and #7 were in the living room watching television. Client #4 stated, "[Client #6] and I had cereal before everyone else got up." Client #2 was in the dining room eating. HM #1 sat in a chair near client #2 and reminded him to chew and take drinks between bites of food. At 7:45 am, DSP #2 took client #1 into the medication room for his second feeding. At 8:00 am, DSP #2 prompted all of the clients to leave for their day program. Client #2 refused to leave and stayed in his bedroom. HM #1 indicated client #2 often refused to leave but might agree when DSP #2 returned with the van. HM #1 was interviewed on 8/31/21 at 8:13 am and stated, "On the evening shift, we need 3 staff to run things smoothly. We usually have 2 staff." HM #1 stated, "One staff cannot pass medications and monitor everyone. [Client #2] needs constant monitoring. The others are ok			

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	with 20 minute checks." Licensed Practical Nurse (LPN) #1 was interviewed on 8/31/21 at 12:00 pm and stated, "[Client #2] should be in line of sight at all times. Staff should always be aware of where he is." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/31/21 at 12:50 pm and stated, "There should be 3 or 4 staff on the first shift, 2 or 3 on the second shift, and 1 or 2 on the overnight shift." QIDP #1 stated, "One staff can supervise everyone during the evening shift." QIDP #1 stated, "[Client #2] does not require supervision at all times. He has an elopement risk. He should be checked on every 20 minutes." QIDP #1 stated, "There is no door on the back of the medication room. It's just a curtain, so staff can hear what is going on. They should be checking between each med pass to make sure everything is ok with the other clients. If they hear the door alarm, they should get up and see who is entering and exiting at that time." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "Normally we have 2 or 3 staff there while the clients are awake. It would be difficult for one staff to do everything." 9-3-3(a)			
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, record review, and interview for 1 of 3 sample clients (#1), the facility	W 0192	The Corvilla Nurse does complete any medical training with all staff. The Corvilla Nurse will	09/30/2021

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	failed to ensure staff were adequately trained to address client #1's health care needs. Findings include: Observations were conducted at the group home on 8/30/21 from 4:00 pm and on 8/31/21 from 6:00 am through 8:30 am. Client #1 was present throughout the observation period. 1. On 8/30/21 at 4:29 pm Direct Support Professional (DSP) #1 brought client #1 in his wheelchair into the medication room. DSP #1 sanitized his hands and put on gloves. DSP #1 crushed client #1's medications and put them in a medication cup. DSP #1 opened a bottle of water and poured some water into the medication cup and stirred it with a spoon. DSP #1 put client #1's liquid and paste medications into a second cup. DSP #1 added water from a water bottle and stirred it with a spoon. At 4:41 pm, DSP #1 opened client #1's g-tube (gastrostomy tube), and a liquid came out of the top. DSP #1 stated, "That happens sometimes." DSP #1 did not use a stethoscope to listen for placement and did not check the g-tube for residual. DSP #1 connected a syringe to the g-tube. DSP #1 poured client #1's liquid medication into the syringe. DSP #1 stated, "[Client #1] isn't supposed to have too much water. No more than one bottle (16.9 ounces) per day." DSP #1 did not wait to see if if the medication was going down the tube. DSP #1 added client #1's crushed medications. DSP #1 did not flush the tube with water before administering medications, between cups of medications, or after administering medications. DSP #1 poured formula into the tube and stated, "He gets half of the box (4 ounces of formula)		randomly check at the homes where this occurs during appropriate times for accuracy and staff competence. The Nurse will also observe feedings at the day program. Any staff found to be in error, we receive immediate retraining and documentation showing that retraining.	

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	now and half in an hour." DSP #1 poured some water into the g-tube and stated, "I didn't measure it. I just put in enough to wash it down." The instructions listed on the formula container were reviewed on 8/31/21 at 4:45 pm and indicated the following: "Additional fluid requirements should be met by giving water between or after feedings or when flushing the tube." 2. On 8/31/21 at 6:40 am, DSP #2 brought client #1 in his wheelchair into the medication room. DSP #2 sanitized her hands and put on gloves. DSP #2 put client #1's liquid medications into a medication cup. DSP #2 crushed client #1's tablet medications. DSP #2 crushed client #1's Erythromycin (antibiotic and gut motility stimulator) separately. DSP #2 used her fingers to pick the casing out of the crushed medications. DSP #2 stated, "We do this one separately then pick the coating out. It'll clog the g-tube." DSP #2 added the crushed medications to the liquid medications. DSP #2 changed her gloves. At 7:10 am, DSP #2 attached a syringe to client #1's g-tube. DSP #2 did not check for placement or residual. DSP #2 poured 1 ounce of water into the g-tube and stated, "We give him 1 ounce before the medications to make sure it's not clogged. He gets one ounce after the medication and one ounce after his feeding." DSP #2 poured the medications into the syringe. There were chunks of powdered medication stuck in the feeding tube. DSP #2 used her fingers to pinch the chunks of medication until they went through the tube. DSP #2 added 1 ounce of water to the syringe and waited for it to go down. DSP #2 stated, "The formula container is 8 ounces. We do 4 ounces now and 4 ounces in one hour." DSP #2 added 4 ounces of formula to the syringe and			

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	waited for it to go down. DSP #2 added 1 ounce of water. Client #1's record was reviewed on 8/31/21 at 9:57 am. Client #1's medication administration record (MAR) for August 2021 indicated the following: "Placement must be checked before each feeding. This is not an option. Check residual/placement before each feeding. Box of Vitale (formula) - give 1/2 box of vitale using g-tube at each feeding. Give 3 oz (ounces) water flush before and after each feeding via g-tube. Give 30 ml water flush before and after 1 pm meds (medications)." House Manager (HM) #1 was interviewed on 8/31/21 at 8:13 am and stated, "We were all trained for the feeding tube. We're supposed to check for residual. We put a stethoscope near the g-tube. We push some air in. If we hear anything, it's not blocked. We flush with 30 ml (milliliters) of water before meds and after feeding." Licensed Practical Nurse (LPN) #1 was interviewed on 8/31/21 at 12:00 pm and stated, "When using the g-tube, staff should check for residual. They should use the syringe and pull back to see how much stomach acid there is. They need to document how much comes back up. They should also listen with a stethoscope. They push in 10 cc (cubic centimeters) of air and listen for gurgles and bubbles. They should check for placement every time they do a feeding or medication." LPN #1 stated, "They should flush with 30 ml of water. They should do a water flush, pass each medication separately with a water flush then do the feed with a water flush." LPN #1 stated, "The dietician and doctor have			

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	said extra water won't hurt." 9-3-3(a)			
W 0210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN 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. Based on record review and interview for 3 of 3 sample clients (#1, #2, and #3), the facility failed to ensure clients #1, #2, and #3 had Comprehensive Functional Assessments (CFAs) completed within 30 days of admission. Findings include: 1. Client #1's record was reviewed on 8/31/21 at 9:57 am. Client #1's record indicated an admission date of 3/26/21. Client #1's record did not include a CFA. 2. Client #2's record was reviewed on 8/31/21 at 11:11 am. Client #2's record indicated an admission date of 10/23/20. Client #2's record did not include a CFA. 3. Client #3's record was reviewed on 8/31/21 at 11:26 am. Client #3's record indicated an admission date of 9/8/20. Client #3's record did not include a CFA. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/31/21 at 12:50 am	W 0210	The Residential Director will review all CFA's and ISPs, as well as active treatment schedules when they are completed. The Residential Director will keep a tracking sheet when items are due and document completion. The QIDP will review all assessments monthly to ensure there are no changes needed.	09/30/2021

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	and stated, "I was not able to find the CFAs. They were not completed. Those should be done at each annual meeting or right when someone moves in." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "The CFA should be completed within 30 days of admission." CCQAD #1 stated, "It determines the strengths and weaknesses. It tells us what skills they already have, what we can build upon to teach them more things. It determines the goals." 9-3-4(a)			
W 0226 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. Based on record review and interview for 2 of 3 sample clients (#1 and #2), the facility failed to develop Individual Service Plans (ISPs) for clients #1 and #2 within 30 days of admission. Findings include: 1. Client #1's record was reviewed on 8/31/21 at 9:57 am. Client #1's record did not include an admission date. Client #1's record did not include an ISP. 2. Client #2's record was reviewed on 8/31/21 at 11:11 am. Client #2's record indicated an admission date of 10/23/20.	W 0226	The Residential Director will review all Individual Support Plans to ensure that they are completed. The Residential director will audit all ISP's and attend all 30 day meetings to ensure quality and completion. The QIDP will be retrained on ISP's, which will include shadowing the residential director during at least 2 annual meetings and at least one 30 day meetings. ISP summaries will be sent to Residential director within72 hours of completion to ensure thoroughness and quality. Corvilla will implement a policy for individual support plans, including within 30 days of admission. This	10/19/2021

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	Client #2's record did not include an ISP. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/31/21 at 12:50 pm and stated, "We were not able to find ISPs for [clients #1 and #2]. They should be completed within 30 days of admission." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "The ISP should be completed within 30 days of admission." CCQAD #1 stated, "The ISP puts together their whole plan. It includes their strengths and weaknesses. What they like and don't like. It has their risk plans and behavior plans. The staff use the ISP to provide care. They should have access to it. We use the ISP to train new staff when they come in to work in the homes. The manager and the QIDP train the staff how to work with the clients using the ISP." CCQAD #1 stated, "We thought the previous QIDP had done it. Apparently it wasn't done." 9-3-4(a)		will be reviewed by the QIDP and Residential Director and will be revised yearly. The Residential Director will keep a tracking sheet when items are due and document completion. This will be sent to the QIDP at the first of the month with all upcoming ISP's outlined - Residential Director and QIDP will also complete an ISP calendar together at the 1st of the year to ensure that all ISP's are being completed within a year of the last ISP.	
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION 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. Based on observation, record review, and interview for 3 of 3 sample clients (#1, #2, and #3), the facility failed to ensure clients #1, #2, and #3's	W 0249	The Residential Director and QIDP will ensure goals are established and reviewed monthly for progress. All documentation	10/20/2021

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	active treatment programs and plans were implemented during formal and informal training opportunities. Findings include: Observations were conducted in the group home on 8/30/21 from 4:00 pm through 5:30 pm with clients #1, #2, #3, #5, #6, and #7 present throughout the observation period, and on 8/31/21 from 6:00 am through 8:15 am with clients #1, #2, #3, #4, #5, #6, and #7 present throughout the observation period. On 8/30/21 at 4:00 pm, clients #1, #2, #3, #5, #6, and #7 arrived to the home with Direct Support Professional (DSP) #1. Maintenance worker #1 was already in the home. Clients #2, #3, #4, #6, and #7 got off the bus and went into the home. DSP #1 used a wheelchair lift to assist client #1 off of the bus. DSP #1 took client #1 into the home. When the surveyor went to the front door, client #7 greeted the surveyor. Client #7 stated, "[DSP #1] is our staff tonight. You can come in." Client #1 was in the living room, and maintenance worker #1 turned on the television for him. Maintenance worker #1 went outside and sat on the front porch with client #2. At 4:03 pm, DSP #1 stated, "One staff is out of town, and the other is on overnight." DSP #1 went into the medication room and shut the door. Client #1 was in the living room watching television. Client #2 was outside with the maintenance staff. Clients #3, #4, #6, and #7 were in their bedrooms. While DSP #1 prepared client #5's medications, the alarm on the front door chimed 3 times. DSP #1 did not leave the medication room to see why the door was being opened. At 4:10 pm, DSP #1 left client #5's		occurs on Therap. This will be reviewed for compliance by the CCQA Director monthly. During random visits, the Residential Director and QIDP will observe staff and persons served and make sure formal as well as informal training is occurring. All staff will be trained on all formal and informal goals, effective 10/20/2021. Staff will be trained on how to integrate training opportunities, such as running medication goals when taking medications, helping with dinner, cleaning up after dinner, and bedtime goals. All goals will be printed and put in the house for staff to have access to 24/7. Active treatment plans will also be printed and put in house. Random visits will occur by QIDP 1x per week when the clients are home to ensure that goals are being completed and the active treatment schedule is being completed. QIDP will make notes to discuss with Residential director. Staff will also be retrained on recording goals onto Therap effective 10/20/2021. QIDP will check every 2-3 days to ensure goals are being documented. If they are not, QIDP will notify house manager who will then ensure staff are completing goals and documenting. If this occurs for	

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	medication on a desk in the medication room and went to call client #5. DSP #1 stated, "I usually do [client #5's] first because he has the most. I save [client #1] for last. His have to be crushed up, and I have to feed him." At 4:16 pm, DSP #1 was in the medication room passing medications with the door closed. Client #1 was in the living room watching television. Client #7 was putting paper plates on the dining table. Client #7 stated, "I'm helping set the table." Client #7 stated, "[Client #3] is in his bedroom. [Client #6] is in his bedroom. [Client #5] is right there in the kitchen. [Client #1] is watching tv. [Client #2] is outside. [Client #4] is at work. He'll be here after 6." At 4:29 pm, DSP #1 brought client #1 into the medication room and gave him his medications and evening meal. At 4:45 pm, the door alarm chimed two times. DSP #1 stated, "Who is coming in and out?" DSP #1 did not open the door to see why the door was being opened. At 4:50 pm, DSP #1 took client #1 out of the medication room. DSP #1 left the medication cabinet unlocked. At 4:51 pm, clients #2, #5, #6, and #7 were in the kitchen looking at pizza boxes on the counter. Client #7 indicated the pizza had been delivered while DSP #1 was passing medications. DSP #1 prompted the clients to wash their hands and help themselves. DSP #1 prompted client #3 to come out of his room for dinner, but he refused. At 4:54 pm, DSP #1 brought client #1 from the living room to the kitchen. Client #1 sat in his wheelchair and watched clients #2, #5, #6, and #7 eat pizza and breadsticks.		more than 1 week without documentation, staff will be retrained and receive a verbal warning.	

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	15G377	A. BUILDING 00 B. WING	09/01/2021

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	At 5:06 pm, client #3 came out of his bedroom and stated, "Is there any left for me?" Client #3 put two slices of pizza on a plate and ate while standing in the kitchen. At 5:14 pm, client #2 asked DSP #1 a question. DSP #1 stated, "I can't take you for a walk today because I have to watch everybody. Maybe we can go tomorrow." DSP #1 was interviewed on 8/30/21 at 5:22 pm and stated, "We usually have enough staff to do everything. [Client #1] should not be left alone. The rest are self sufficient. [Client #2] gets a little excited. He's going through dementia." On 8/31/21 at 6:00 am, the surveyor was greeted at the door by DSP #2. DSP #2 stated, "I'll be passing medications while [House Manager (HM) #1] helps [client #1]." From 6:03 am until 6:31 am, HM #1 was in client #1's bedroom assisting him with toileting and dressing tasks. DSP #2 was in the medication room with the door shut from 6:03 am until 7:15 am. At 6:45 am, clients #2, #5, and #7 were in the kitchen. Client #7 opened the freezer door and took out a box of frozen breakfast sandwiches. Client #7 handed a breakfast sandwich to clients #2 and #5. Clients #2, #5, and #7 each took turns warming their sandwiches in the microwave then sat down to eat at the table. Client #1 was sitting in the living room in front of the television. Clients #3, #4, and #6 were in their bedrooms. At 7:00 am, clients #1, #4, #6, and #7 were in the living room watching television. Client #4 stated, "[Client #6] and I had cereal before everyone else got up." Client #2 was in the dining room eating. HM #1 sat in a chair near client #2 and reminded him to chew and take drinks between bites of			

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	food. At 7:45 am, DSP #2 took client #1 into the medication room for his second feeding. At 8:00 am, DSP #2 prompted all of the clients to leave for their day program. Client #2 refused to leave and stayed in his bedroom. HM #1 indicated client #2 often refused to leave but might agree when DSP #2 returned with the van. HM #1 was interviewed on 8/31/21 at 8:13 am and stated, "On the evening shift, we need 3 staff to run things smoothly. We usually have 2 staff." HM #1 stated, "One staff cannot pass medications and monitor everyone. [Client #2] needs constant monitoring. The others are ok with 20 minute checks." Licensed Practical Nurse (LPN) #1 was interviewed on 8/31/21 at 12:00 pm and stated, "[Client #2] should be in line of sight at all times. Staff should always be aware of where he is." Client #1's record was reviewed on 8/31/21 at 9:57 am and did not include an Individual Service Plan (ISP) or an Active Treatment schedule. Client #2's record was reviewed on 8/31/21 at 11:11 am and did not include an ISP or an Active Treatment Schedule. Client #3's record was reviewed on 8/31/21 at 11:26 am and did not include an active treatment schedule. Client #3's ISP dated 10/7/20 indicated the following goals: Medication, dental hygiene, showering, money management, domestic skills, and nutrition. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/31/21 at 12:50 pm and stated, "There should be 3 or 4 staff on the			

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	first shift, 2 or 3 on the second shift, and 1 or 2 on the overnight shift." QIDP #1 stated, "One staff can supervise everyone during the evening shift." QIDP #1 stated, "[Client #2] does not require supervision at all times. He has an elopement risk. He should be checked on every 20 minutes." QIDP #1 stated, "There is no door on the back of the medication room. It's just a curtain, so staff can hear what is going on. They should be checking between each med pass to make sure everything is ok with the other clients. If they hear the door alarm, they should get up and see who is entering and exiting at that time." QIDP #1 indicated staff should implement goals as frequently as stated in the program plans. Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "Normally we have 2 or 3 staff there while the clients are awake. It would be difficult for one staff to do everything." CCQAD #1 stated, "Staff should be running goals. We train staff to involve everyone in everything to the best of their abilities. If staff are cooking or doing laundry, clients should be assisting and participating in active treatment to the best of their ability. They should be participating in daily living skills. If clients are in their room, staff should make contact with them and attempt to engage them." 9-3-4(a)			
W 0250 Bldg. 00	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.	W 0250	The Residential Director and QIDP	10/20/2021

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	Based on record review and interview for 3 of 3 sample clients (#1, #2, and #3), the facility failed to develop active treatment schedules for clients #1, #2, and #3. Findings include: 1. Client #1's record was reviewed on 8/31/21 at 9:57 am and did not include an active treatment schedule. 2. Client #2's record was reviewed on 8/31/21 at 11:11 am and did not include an active treatment schedule. 3. Client #3's record was reviewed on 8/31/21 at 11:26 am and did not include an active treatment schedule. Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "There should be active treatment schedules. It should include their daily routine and events." 9-3-4(a)		and the House Manager will ensure through observation that the active treatment schedules are followed each day by staff. The Residential Director will keep a tracking sheet when schedules are due and document completion. Any changes will be made as warranted. Active treatment schedules for all clients were completed on 9/30/2021. They are located both on Therap and in the house to ensure that staff has access to them. Staff were trained on active treatment schedules and QIDP is making weekly visits to ensure that they are being followed.	
W 0252 Bldg. 00	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to ensure client #3's goals were implemented and recorded as indicated in his Individual Service Plan (ISP). Findings include:	W 0252	The Residential Director and QIDP will ensure goals are established and reviewed monthly for progress. All documentation occurs on Therap. This will be reviewed for compliance by the CCQA Director monthly and staff	09/30/2021

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	Client #3's record was reviewed on 8/31/21 at 11:26 am. Client #3's ISP dated 10/7/20 indicated the following goals: "[Client #3] will create a weekly budget with staff assistance. Schedule: Weekly." - Client #3's record indicated the goal was run 0 times in May, June, and July 2021. "[Client #3] will clean his bedroom 1x (time) per week. Schedule: Weekly." - Client #3's record indicated the goal was run 0 times in May, 1 time in June, and 0 times in July 2021. "[Client #3] will 'pop' his medications. Schedule: Daily." - Client #3's record indicated the goal was run 0 times in May, 1 time in June, and 0 times in July 2021. "[Client #3] will brush his teeth for 2 1/2 minutes 2 x daily. Schedule: Daily." - Client #3's record indicated the goal was run 0 times in May, 1 time in June, and 0 times in July 2021. "[Client #3] will assist staff in preparing 1 meal per week. Schedule: Weekly." - Client #3's record indicated the goal was run 0 times in May, June, and July 2021. "[Client #3] will take a complete shower daily. Schedule: Daily."		will receive corrective action if not completed. During random visits, the Residential Director and QIDP will observe staff and persons served and make sure formal as well as informal training is occurring. Staff will also be retrained on recording goals onto Therap effective 10/20/2021. QIDP will check every 2-3 days to ensure goals are being documented electronically. If they are not, QIDP will notify house manager who will then ensure staff are completing goals and documenting. If this occurs for more than 1 week without documentation, staff will be retrained and receive a verbal warning. All goals will be available within the house in case there are technological problems. All goals will be available for all staff 48 hours after being updated. Corvilla does discuss goal documentation during New Staff Orientation. Corvilla will be adding goal documentation to the training sheets for new staff. This will be completed in home with the group home manager.	

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	- Client #3's record indicated the goal was run 0 times in May, 1 time in June, and 0 times in July 2021. House Manager (HM) #1 was interviewed on 8/31/21 at 8:13 am and stated, "The clients have goals. We're supposed to do them every day and record it." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 8/31/21 at 1:00 pm and stated, "Staff should be running goals. Some are done daily. Some are twice a week. It depends on the goal. They should document when the goal is run." 9-3-4(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview for 1 additional client (#6), the facility failed to administer client #6's medications as ordered. Findings include: Observations were conducted at the group home on 8/31/21 from 6:00 am through 8:30 am. Client #6 was present for the duration of the observation period. On 8/31/21 at 6:36 am, Direct Support Professional (DSP) #2 passed client #6's medications. DSP #2 put client #6's medications into a medication cup. DSP #2 handed the medication cup to client #6.	W 0369	The Residential Director, QIDP, Corvilla Nurse and CCQA will go to each group home weekly at medication times and observe med passes for accuracy. Any errors found will result in retraining of the staff including retaking medication administration if needed. The Corvilla Nurse will also observe all new staff in their first week working in the homes passing medication, for accuracy and compliance.	09/30/2021

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	Client #6 swallowed half of the pills with water then swallowed the other half. Client #6's pharmacy packaging indicated the following: "Vitamin C (supplement), 500 mg (milligrams), 1 per day, chewable." Client #6's medical record was reviewed on 8/31/21 at 7:00 am. Client #6's medication administration record (MAR) for August, 2021 indicated the following: "Vitamin C, 500 mg, chewable. Vitamin C, 500 mg tablet, chew. Chew 1 tablet by mouth every day." Licensed Practical Nurse (LPN) #1 was interviewed on 8/31/21 at 12:00 pm and stated, "The chewable medications are usually bigger. It should be given separately and chewed. It shouldn't be swallowed. Staff should follow the orders." 9-3-6(a)			
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 3 of 3 sample clients (#1, #2, and #3), plus 4 additional clients (#4, #5, #6, and #7), the facility failed to ensure clients #1, #2, #3, #4, #5, #6, and #7's medications were kept locked when not in use. Findings include: Observations were conducted in the group home	W 0382	The Residential Director, QIDP, Corvilla Nurse and CCQA will go to each group home weekly at medication times and observe med passes for accuracy, including privacy during med passes and securing meds properly. Any errors found will result in retraining of the staff including retaking medication	09/30/2021

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	on 8/31/21 from 4:00 pm through 5:30 pm. Clients #1, #2, #3, #5, #6, and #7 were present in the home throughout the observation period. Direct Support Professional (DSP) #1 was in the medication room passing medications from 4:03 pm until 4:50 pm. When DSP #1 left the medication room, both filing cabinets containing medication were left unlocked. The door to the medication room was shut but was not locked. The back wall of the medication room is covered by a curtain and is open to the dining room and a bathroom. The medications remained unlocked until the end of the observation period at 5:30 pm. Licensed Practical Nurse (LPN) #1 was interviewed on 8/31/21 at 12:00 pm and stated, "Medications should be locked when staff aren't in the medication room. Controlled medications should be double locked." 9-3-6(a)		administration if needed. The Corvilla Nurse will also observe all new staff in their first week working in the homes passing medication, for accuracy and compliance.	
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, interview, and record review for 3 of 3 sample clients (#1, #2, and #3), plus 4 additional clients (#4, #5, #6, and #7), the facility failed to ensure staff working in the home implemented proactive/preventative COVID-19 infection control measures during a world wide pandemic and to follow universal precautions in regards to client #1's personal care. Findings include:	W 0455	The Residential Director, Nurse, QIDP, CCQA, and the House Manager, will be looking for infection control practices during all observations. Corrections will be made immediately if observed and retraining provided if necessary. The Residential Director, Nurse, QIDP, CCQA, and the House Manager, will be looking for infection control practices during all observations.	09/30/2021

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	Observations were conducted at the group home on 8/30/21 from 4:00 pm through 5:30 pm with clients #1, #2, #3, #5, #6, and #7 present for the duration of the observation period and on 8/31/21 from 6:00 am through 8:30 am with clients #1, #2, #3, #4, #5, #6, and #7 present for the duration of the observation period. 1. On 8/30/21 at 4:00 pm, the surveyor was welcomed into the group home. Client #7 answered the door and stated, "[Direct Support Professional (DSP) #1] is the only staff here tonight." The surveyor was not screened for symptoms of COVID-19 or for a temperature. 2. On 8/31/21 at 6:00 am, the surveyor was welcomed into the group home by DSP #2. DSP #2 took the surveyor's temperature and indicated it was within the normal range. DSP #2 did not screen the surveyor for symptoms of COVID-19. 3. On 8/31/21 at 6:10 am, House Manager (HM) #1 put on gloves and changed client #1's brief. HM #1 applied petroleum jelly to an open wound on client #1's tailbone. HM #1's gloves were visibly soiled with petroleum jelly. HM #1 did not change his gloves or wash or sanitize his hands after toileting client #1. HM #1 changed client #1's clothes, applied moisturizer to his lips, and transferred him into his wheelchair. HM #1 was interviewed on 8/31/21 at 8:13 am and stated, "Visitors should be screened for COVID. Staff should ask about fever, symptoms, if the person has traveled. They should take the visitor's temperature." HM #1 stated, "Staff should wash their hands after toileting clients and helping with hygiene." Licensed Practical Nurse (LPN) #1 was		Corrections will be made immediately if observed and retraining provided if necessary.	

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	interviewed on 8/31/21 at 12:00 pm and stated, "Staff should be taking visitors' temperatures when they arrive. There are also screening questions." LPN #1 stated, "Staff should be washing their hands after toileting a client or applying ointments. They should change gloves and wash their hands." The facility's Communicable Disease Policy dated March 2020 was reviewed on 8/31/21 at 2:30 pm and indicated the following: "Procedure: 2. Employees will consistently take sanitary measures and barrier precautions that will prevent the spread of communicable diseases. They will also help persons receiving services do the same.... Barrier Precautions 1. Avoid contact with body fluids. A disposable gloves are available. 1. Use whenever come (sic) into contact with body fluids. 2. Change gloves after each client. B. Wash hands after removing gloves.... IV. Handwashing technique. A. Proper handwashing requires the use of soap and water and vigorous washing under a stream of running water for approximately 20 seconds. B. Do not allow hands to chaff, use moisturizing lotion when necessary." 9-3-7(a)			