STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G636	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

(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 pre-determined full recertification and state licensure survey. Dates of Survey: February 26, 27, 28, 29, March 1, 4, 5, 6, and 7, 2024. Facility Number: 001212 Provider Number: 15G636 Aims Number: 100240190 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/20/24.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review, 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 meet the Condition of Participation: Governing Body. The governing body failed to implement general policy, budget, and operating direction over the home to ensure clients #1, #2, #3, #4, #5, #6, and #7's home was in good repair, to ensure clients #1, #2, and #3's active treatment programs were consistently and aggressively implemented, to ensure client #3 had a Comprehensive Functional Assessment (CFA) completed within 30 days of admission, to ensure clients #1 and #2 had nutrition assessments completed, to develop an Individual Support Plan (ISP) for client #3 within	W 0102	Cleaning checklists are turned into the QIDP each week. Managers are checking to make sure the cleaning duties are completed. Morning staff were retrained to walk through the home after returning from AM transport and check all areas for cleanliness including the toilets on 3-8-2024. All staff were retrained on cleaning checklists on 3-8-24 and completing them. Periodic checks will be done during the day by the QIDP, Residential Director, and DCCQA when no one is home to ensure compliance. This check will include checking all furniture	03/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dan Peterson	DCCQA	03/28/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	30 days of admission to the group home, to effectively implement clients #1, #2, and #3's active treatment programs at all opportunities, to ensure clients #1 and #2 had Individual Support Plans (ISPs), and to develop a Behavior Support Plan (BSP) to address client #2's maladaptive behaviors. Findings include: 1. The governing body failed to implement general policy, budget, and operating direction over the home to ensure clients #1, #2, and #3's active treatment programs were consistently and aggressively implemented and to ensure clients #1, #2, #3, #4, #5, #6, and #7's home was in good repair. Please see W104. 2. The governing body failed to ensure clients #1, #2, and #3's active treatment programs were consistently and aggressively implemented, to ensure client #3 had a Comprehensive Functional Assessment (CFA) completed within 30 days of admission, to ensure clients #1 and #2 had nutrition assessments completed, to develop an Individual Support Plan (ISP) for client #3 within 30 days of admission to the group home, to effectively implement clients #1, #2, and #3's active treatment programs at all opportunities, to ensure clients #1 and #2 had Individual Support Plans (ISPs), and to develop a Behavior Support Plan (BSP) to address client #2's maladaptive behaviors. Please see W195. 9-3-1(a)		to ensure good repair. This will occur at all 4 group homes. Any cleaning issues found will be immediately corrected and the staff responsible will receive corrective action. The missing CFA was completed and reviewed on March 11, 2024. All CFA's at all homes were reviewed for compliance. The Residential Director or DCCQA will review CFA"s annually for compliance or within 30 days of a new admission or if changes are warranted throughout the year. The QIDP has a tracking sheets for all needed items including CFA's. This checklist will be reviewed monthly by the Residential Director or DCCQA. Staff was retrained on active treatment on 3-8-24 and again on 3-28-24. Active treatment will be observed by the manager and corrected if not occurring. Active treatment will also be checked during random observations by the QIDP, Residential Director, or DCCQA. Active treatment schedules are done for each person and staff were trained on 3-8-24 and 3-28-24. This is complete for all homes. The BSP was completed for the person missing one. All homes were reviewed for any missing BSP's. Staff were trained on this BSP on 3-28-2024. The QIDP has a checklist of all BSP's and when they are due. The	

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			DCCQA or Residential Director will review monthly to ensure compliance.	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview for 3 of 3 sample clients (#1, #2, and #3), plus 4 additional clients (#4, #5, #6, and #7), the facility's governing body failed to implement general policy, budget, and operating direction over the home to ensure clients #1, #2, and #3's active treatment programs were consistently and aggressively implemented and to ensure clients #1, #2, #3, #4, #5, #6, and #7's home was in good repair. Findings include: 1. The governing body failed to ensure clients #1, #2, and #3's active treatment programs were consistently and aggressively implemented. Please see W196. 2. Observations were conducted in the group home on 2/26/24 from 3:15 pm to 5:30 pm and on 2/27/24 from 5:40 am to 8:00 am. Clients #1, #2, #3, #4, #5, #6, and #7 were present in the home throughout the observation periods. On 2/26/24 at 3:15 pm, Direct Support Professional (DSP) #1 was in the home preparing the evening meal. Clients #1, #2, #3, #4, #5, #6, and #7 had not arrived home from their day program. On the men's side of the home, there was feces on the seat of the toilet. When clients #1, #2, #3, #4, #5, #6, and #7 arrived home at 3:40 pm, the toilet had	W 0104	Cleaning checklists are turned into the QIDP each week. Managers are checking to make sure the cleaning duties are completed. Morning staff were retrained to walk through the home after returning from AM transport and check all areas for cleanliness including the toilets on 3-8-2024. All staff were retrained on cleaning checklists on 3-8-24 and completing them. Periodic checks will be done during the day by the QIDP, Residential Director, and DCCQA when no one is home to ensure compliance. This check will include checking all furniture to ensure good repair. This will occur at all 4 group homes. Any cleaning issues found will be immediately corrected and the staff responsible will receive corrective action. The missing CFA was completed and reviewed on March 11, 2024. All CFA's at all homes were reviewed for compliance. The Residential Director or DCCQA will review CFA"s annually for compliance or within 30 days of a new admission or if changes are	03/31/2024

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	not been cleaned. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "The toilet should be cleaned daily and overnight. Staff should also check the bathroom after it has been used." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "The toilet should be cleaned immediately after it is used." Chief Operations Officer (COO) #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "The toilet should be cleaned after use when there is evidence of feces or bodily fluid. It should be cleaned before everybody gets back home in the afternoon." 3. Throughout the observation periods, a recliner on the women's side of the home had a rip in the seat measuring 18 inches in width. QIDP #1 was interviewed on 2/28/24 at 2:11 pm and stated, "The ripped recliner has not been reported. I didn't know about it. Staff should have reported it. It should be replaced or repaired." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "I haven't heard anything about the recliner. Staff should report maintenance issues. The manager fills out a monthly report." COO #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "Staff should report that. We have a safety committee that does site checks.		warranted throughout the year. The QIDP has a tracking sheets for all needed items including CFA's. This checklist will be reviewed monthly by the Residential Director or DCCQA. Staff was retrained on active treatment on 3-8-24 and again on 3-28-24. Active treatment will be observed by the manager and corrected if not occurring. Active treatment will also be checked during random observations by the QIDP, Residential Director, or DCCQA. Active treatment schedules are done for each person and staff were trained on 3-8-24 and 3-28-24. Schedules are complete for all homes. The BSP was completed for the person missing one. All homes were reviewed for any missing BSP's. Staff were trained on this BSP on 3-28-2024. The QIDP has a checklist of all BSP's and when they are due. The DCCQA or Residential Director will review monthly to ensure compliance.	

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	Someone does a site check and should have seen that. Maintenance and staff could also pay attention to it. The recliner should be repaired or replaced." 9-3-1(a)			
W 0111 Bldg. 00	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. 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's records were complete and accurate. Findings include: 1. Client #1's record was reviewed on 2/28/24 at 12:23 pm and indicated an admission date of 1/15/93. Client #1's record indicated a Comprehensive Functional Assessment (CFA) dated 12/9/23. Client #1's record did not include an Individual Support Plan (ISP). Client #1's medical record was in piles in the nurse's office and was not readily available for review. 2. Client #2's record was reviewed on 2/27/24 at 1/28/24 at 11:24 am and indicated an admission date of 1/3/14. Client #2's record indicated a CFA dated 9/30/23. Client #2's record did not include an ISP. Client #2's physician orders indicated medications prescribed for maladaptive behaviors, but client #2 did not have a Behavior Support Plan (BSP).	W 0111	ISP's will be included on the QIDP's checklist of documents. This checklist will be reviewed monthly by the Residential Director or DCCQA to ensure all items are current. All homes will be reviewed monthly. The BSP was completed for the person missing one. All homes were reviewed for any missing BSP's. Staff were trained on this BSP on 3-28-2024. The QIDP has a checklist of all BSP's and when they are due. The DCCQA or Residential Director will review monthly to ensure compliance. The missing CFA was completed and reviewed on March 11, 2024. All CFA's at all homes were reviewed for compliance. The Residential Director or DCCQA will review CFA"s annually for compliance or within 30 days of a new admission or if changes are warranted throughout the year.	03/31/2024

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	Client #2's medical record was in piles in the nurse's office and was not readily available for review. 3. Client #3's record was reviewed on 2/27/24 at 2:50 pm and indicated an admission date of 10/7/23. Client #3's record did not include a CFA or an ISP. Client #3's medical record was in piles in the nurse's office and was not readily available for review. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "We looked for the ISPs and could not find them. I know they were done. We just can't find them." Registered Nurse (RN) #1 was interviewed on 2/27/24 at 2:00 pm and stated, "I'm looking for the medical records you need. They are all in piles in the office. We're having to go through the piles page by page to find everything." Chief Operations Officer (COO) #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "Organization is a work in progress. This home has been on the to do list. Records should be up to date and in order. Everyone should have access to the documents they need." 9-3-1(a)		The QIDP has a tracking sheets for all needed items including CFA's. This checklist will be reviewed monthly by the Residential Director or DCCQA.	
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 3 of 12 allegations of abuse and neglect reviewed	W 0149	All discharge orders will be reviewed by the nurse and the	03/31/2024

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	affecting client #3, the facility failed to implement its written policy and procedure to prevent 3 allegations of neglect of client #3's health care needs. Findings include: The facility's Bureau of Disabilities Services (BDS) reports and related investigations were reviewed on 2/27/24 at 11:50 am. 1. A BDS report written by the agency nurse and dated 10/19/23 indicated the following: "Today at day program, agency nurse went to get vitals on a (sic) [client #3] to complete an assessment when it was discovered a large bruise/lump measuring more than 6 inches in length and 2 inches wide on the right side of scalp, smaller bruise measuring about 2 inches in length wrapping around behind the right ear. Both areas appear bright red and purple in color. [Client #3's] vitals were out of range with bp (blood pressure) and pulse being high, pupils not dilating, and [client #3] appeared more tired than usual. House Manager was notified that agency nurse was sending [client #3] to the ER (emergency room) via ambulance. House Manager was asked if he had seen a bruise on [client #3's] scalp on Wednesday (10/18/23). Manager stated that he did not have any bruising last night when showered exception (sic) for the inside of right ear from a fall earlier this week (10/16/23) that showed up this week on Wednesday (10/18/23).... [Client #3] arrived at the ER, and staff met him there. While at the ER, CT (computerized tomography) scan of neck/head and x-ray ordered and completed. No abnormal findings. Labs were ordered and completed, and labs showed [client #3's] sodium was depleted. [Client #3] was admitted to the hospital."		nurse is responsible to ensure staff complete any follow-up appointments and obtain follow-up medications. Going forward, the DCCQA will receive discharge orders as well and will work with the nursing staff to ensure all follow-up appointments are completed and medications received. This will ensure the DCCQA will know if appointments are not completed, and an IR can be filed for neglect and staff disciplined. Any wrong medications administered upon knowledge will continue to be reported as required. Any delays with the pharmacy in obtaining medications will be documented. All staff were retrained that any discrepancies between he MAR and the medication label are to be addressed at once with he nurse. This incident was investigated and reported, and staff received corrective action. The Nursing staff were retrained that the MAR and labels need to match and if is a question, ask immediately.	

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	Client #3's record was reviewed on 2/27/24 at 2:50 pm and indicated an admission date of 10/7/23. Client #3's hospital discharge orders dated 10/20/23 indicated the following: "He should have repeat BMP (Basic Metabolic Panel) on Monday 10/23/23 to reevaluate his sodium with results to his PCP (primary care physician)." Client #3's hospital discharge orders dated 10/20/23 indicated a prescription for Sodium Chloride (salt)1 g (gram) twice daily." Client #3's record did not indicate a follow up BMP on 10/23/23. Client #3's Medication Administration Record (MAR) for October 2023 indicated he did not receive sodium chloride until 10/30/23. 2. A BDS report written by the agency nurse and dated 10/25/23 indicated the following occurred on 10/24/23: "Staff alerted nurse to new bruising on [client #3's] shoulders. Upon investigating, it was noted by nurse that [client #3] had a new lump on the right side of scalp, slightly below the current bruise he has. It appeared that it had dry blood present, no active bleeding. Staff let nurse know that [client #3's] nose was bleeding on and off, and he appeared to be more tired than usual. [Client #3] does have a history of nose bleeds, but, due to the new lump, agency nurse did not want to chance it. [Client #3] was sent out to the ER via ambulance. Staff met [client #3] at the ER, and, once at the ER, doctor ordered and completed labs and a CT scan. CT scan was normal. Blood work showed that [client #3's] sodium was again depleted. Staff asked about bruises, and the nurse stated that all the bruises			

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	seem old and in various stages of healing. The hematoma on (sic) head was also stated by nurse that it appears that it was caused by the recent fall he had the prior week (10/16/23). Doctor believes one of [client #3's] seizures (sic) medications may be the cause of his sodium depletion. [Client #3] was admitted for more testing." Client #3's hospital record indicated the following physician note on 10/24/23: "Labs here reveal a sodium of 120 which was lower than his last admission. He does not have a med administration record with him. I cannot see that the salt tabs were filled, however, they may have gotten them from an outside pharmacy. Due to his critical hyponatremia, admission is required. I called and updated his father. He states the patient had been fairly well controlled with a seizure until he recently moved to the group home. There have been some miscommunication on his medications, and so he started having breakthrough seizures again.... His parents are aware of low sodium levels in the past, however, it is unknown to them what was done about it." Client #3's hospital record indicated the following physician note on 10/26/23: "[Client #3] was found to have severe hyponatremia and was admitted for work-up and treatment. He was given a liter of saline and restarted on salt tabs. His sodium rapidly normalized. I spoke with his nurse at this group home, and she was unaware that he was to be initiated on salt tabs after his last hospitalization. I faxed her the prescription for the salt tabs. Patient was back to baseline and will be discharged back to his group home in stable condition." Client #3's record indicated he was discharged			

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	from the group home on 10/26/23 with a prescription for sodium chloride 1 g twice daily. Client #3's MAR for October 2023 indicated he did not receive sodium chloride until 10/30/23. 3. A BDS report dated 11/29/23 indicated the following: "On 11/29/23 it was discovered that the pharmacy sent the wrong medication for [client #3]. [Client #3] is prescribed Sodium Chloride 1 mg (milligram) (sic) twice per day. The pharmacy sent Sodium Bicarbonate (antacid) 650 mg twice per day. The wrong medication had been given since 11/22/2023 which totals 13 doses. The correct medication, Sodium Chloride was picked up today and will start tonight. [Client #3's] PCP was notified of the error." An investigation dated 12/1/23 indicated the following: "Staff should not have been giving the medication as what was on the card did not match the MAR and doctor's order. Staff did not follow the medication administration policy and did not complete compliance checks three times before passing the medication, ensuring the medication card and MAR match. When they don't match, they should not administer the medication and contact the nurse immediately. The pharmacy also made a mistake in their packing and compliance checks." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "There should be a collaborative effort between the health and wellness coordinator and the nurse to ensure medications are given. The QIDP should be aware of medication changes. The ideal is to have the prescription and medications in the home when the client returns			

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	from the hospital. Sometimes the procedure is impossible to implement. The nurse should have been aware of the medication change." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "I know his sodium was depleted, that's why he was in the hospital on the 19th. The nurse would be responsible for making sure the new medication was available." Health and Wellness Coordinator (HWC) #1 was interviewed by phone on 2/29/24 at 12:41 pm and stated, "Usually, the nurse should look at the discharge summary before they are discharged. The nurse should review the level of care and any new prescriptions, we have to try to have everything in place prior to discharge. We try to make sure, the day before discharge, they are sending the instructions over, so they can be reviewed. The nurse should have checked to make sure the prescription was ready to go before [client #3] arrived home." HWC #1 stated, "I picked up the sodium bicarbonate. The pharmacy said, 'Yes, that's what he has ordered.' I inquired of the doctor, and he said, 'That's not the right medication.' The pharmacy was doing an investigation of why it happened. It should have been caught when they were filling it. I thought it was a change on the name, not realizing it was the wrong medication. I directed staff to change the MAR and write it in as sodium bicarbonate." The facility's nursing staff was not available for interview at the time of the survey. The facility's undated Incident Reporting and Management Policy was reviewed on 2/27/24 at 12:00 pm and indicated the following:			

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	"It is the policy of Corvilla, Inc. to: Ensure the health and safety of all its clients.... Alleged, suspected or actual neglect which includes but is not limited to: - Failure to provide appropriate supervision, care, or training; - Failure to provide a safe, clean, and sanitary environment; - Failure to provide food and medical services as needed; - Failure to provide medical supplies or safety equipment as indicated in the Individualized Support Plan (ISP).... Incidents involving abuse, neglect, exploitation, peer-to-peer aggression, criminal activity, aversive techniques, and use of medical restraints are to be refereed to the Human Right Officer of Corvilla immediately. The Human Right Officer will file timely reports on all allegations received. All other reportable incidents as defined above are the responsibility of the client's Qualified Intellectual Disabilities Professional (QIDP) or Program Manager.... All immediate steps will be taken to protect the individual who has been or alleged to have been the victim of abuse, neglect, exploitation, or mistreatment from further abuse, neglect, exploitation, or mistreatment.... Incidents that will be investigated include abuse, neglect, exploitation that is witnesses, suspected, or alleged.... In all cases, incident reports must be sent within 24 hours to the Bureau of Quality Improvement Services (BQIS). A copy of this electronic report will also be forwarded to the following people within 24 hours as appropriate: ... The individual's BDS Service Coordinator...." 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G636	A. BUILDING 00 B. WING	03/07/2024

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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 observation, record review, and interview for 3 of 3 sample clients (#1, #2, and #3), the Qualified Intellectual Disabilities Professional (QIDP) failed to effectively integrate, coordinate, and monitor clients #1, #2, and #3's active treatment programs. The QIDP failed to ensure clients #1, #2, and #3's active treatment programs were consistently and aggressively implemented, to ensure client #3 had a Comprehensive Functional Assessment (CFA) completed within 30 days of admission, to ensure clients #1 and #2 had nutrition assessments completed, to develop an Individual Support Plan (ISP) for client #3 within 30 days of admission to the group home, to effectively implement clients #1, #2, and #3's active treatment programs at all opportunities, to ensure clients #1 and #2 had ISPs, and to develop a Behavior Support Plan (BSP) to address client #2's maladaptive behaviors. Findings include: 1. The QIDP failed to ensure clients #1, #2, and #3's active treatment programs were consistently and aggressively implemented. Please see W196. 2. The QIDP failed to ensure client #3 had a CFA completed within 30 days of admission. Please see W210. 3. The QIDP failed to ensure clients #1 and #2 had	W 0159	The missing CFA was completed and reviewed on March 11, 2024. All CFA's at all homes were reviewed for compliance. The Residential Director or DCCQA will review CFA"s annually for compliance or within 30 days of a new admission or if changes are warranted throughout the year. The QIDP has a tracking sheets for all needed items including CFA's. This checklist will be reviewed monthly by the Residential Director or DCCQA. Staff was retrained on active treatment on 3-8-24 and again on 3-28-24. Active treatment will be observed by the manager and corrected if not occurring. Active treatment will also be checked during random observations by the QIDP, Residential Director, or DCCQA. Active treatment schedules are done for each person and staff were trained on 3-8-24 and 3-28-24. This is complete for all homes. The BSP was completed for the person missing one. All homes were reviewed for any missing BSP's. Staff were trained on this BSP on 3-28-2024. The QIDP has a checklist of all BSP's and when they are due. The	03/31/2024

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	nutrition assessments completed. Please see W217. 4. The QIDP failed to develop an ISP for client #3 within 30 days of admission to the group home. Please see W226. 5. The QIDP failed to effectively implement clients #1, #2, and #3's active treatment programs at all opportunities. Please see W249. 6. The QIDP failed to ensure clients #1 and #2 had ISPs. Please see W260. 7. The QIDP failed to develop a BSP to address client #2's maladaptive behaviors. Please see W312. 9-3-3(a)		DCCQA or Residential Director will review monthly to ensure compliance. The nutritional assessment was completed. The dietician provided a copy. Corvilla has copies of all nutritional assessments now. A schedule was provided by the dietician for when she will be doing her annual assessments. The DCCQA will check for compliance based on those dates provided. ISP's will be included on the QIDP's checklist of documents. This checklist will be reviewed monthly by the Residential Director or DCCQA to ensure all items are current. All homes will be reviewed monthly.	
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 failed to ensure staff working in the home were adequately trained to use clients #1's dining harnesses. Findings include: An observation was conducted in the group home on 2/26/24 from 3:15 pm to 5:30 pm. Client #1 was present in the home throughout the observation period.	W 0192	Staff were retrained on using the dining harness correctly on 3-8-24 and again on 3-28-24. Compliance with this will occur with observations from the manager and random observations by the QIDP, Residential Director or DCCQA. Staff who uses incorrectly will receive corrective action. The other home where dining harness is used will also be checked for this for compliance.	03/31/2024

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	On 2/26/24 at 5:07 pm, client #1 sat at the dining table, and staff assisted her with her cloth dining harnesses. The dining harnesses had Velcro closures, but staff tied it over the client #1's shoulders to the top of the chair and under her arms to the back of the chair. At 5:12 pm, Direct Support Professional (DSP) #4 stated, "What is Velcro? That's how it is. I don't know." Client #1's record was reviewed on 2/28/24 at 12:23 pm. Client #1's dining plan dated July 2023 indicated the following: "Staff are to ensure that [client #1] has her dining harness in place for all meals and snacks and dining harness to remain on for 30 minutes after meals as tolerated." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "Tying the harness is not appropriate. There's no breakaway. Staff should be trained on how to use them." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "Staff should be using the Velcro. If the clients want to take it off, they need to be able to take it off." Chief Operations Officer #1 was interviewed by phone on 3/1/24 at 9:46 pm and stated, "The dining harnesses should not be tied. Staff need to be trained." 9-3-3(a)			
W 0195 Bldg. 00	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active			

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	treatment services requirements are met. Based on observation, record review, and interview for 3 of 3 sample clients (#1, #2, and #3), the facility failed to meet the Condition of Participation: Active Treatment. The facility failed to ensure clients #1, #2, and #3's active treatment programs were consistently and aggressively implemented, to ensure client #3 had a Comprehensive Functional Assessment (CFA) completed within 30 days of admission, to ensure clients #1 and #2 had nutrition assessments completed, to develop an Individual Support Plan (ISP) for client #3 within 30 days of admission to the group home, to effectively implement clients #1, #2, and #3's active treatment programs at all opportunities, to ensure clients #1 and #2 had ISPs, and to develop a Behavior Support Plan (BSP) to address client #2's maladaptive behaviors. Findings include: 1. The facility failed to ensure clients #1, #2, and #3's active treatment programs were consistently and aggressively implemented. Please see W196. 2. The facility failed to ensure client #3 had a CFA completed within 30 days of admission. Please see W210. 3. The facility failed to ensure clients #1 and #2 had nutrition assessments completed. Please see W217. 4. The facility failed to develop an ISP for client #3 within 30 days of admission to the group home. Please see W226.	W 0195	The missing CFA was completed and reviewed on March 11, 2024. All CFA's at all homes were reviewed for compliance. The Residential Director or DCCQA will review CFA"s annually for compliance or within 30 days of a new admission or if changes are warranted throughout the year. The QIDP has a tracking sheets for all needed items including CFA's. This checklist will be reviewed monthly by the Residential Director or DCCQA. Staff was retrained on active treatment on 3-8-24 and again on 3-28-24. Active treatment will be observed by the manager and corrected if not occurring. Active treatment will also be checked during random observations by the QIDP, Residential Director, or DCCQA. Active treatment schedules are done for each person and staff were trained on 3-8-24 and 3-28-24. This is complete for all homes. The BSP was completed for the person missing one. All homes were reviewed for any missing BSP's. Staff were trained on this BSP on 3-28-2024. The QIDP has a checklist of all BSP's and when they are due. The DCCQA or Residential Director will review monthly to ensure compliance. The nutritional assessment was completed. The dietician	03/31/2024

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	5. The facility failed to effectively implement clients #1, #2, and #3's active treatment programs at all opportunities. Please see W249. 6. The facility failed to ensure clients #1 and #2 had ISPs. Please see W260. 7. The facility failed to develop a BSP to address client #2's maladaptive behaviors. Please see W312. 9-3-4(a)		provided a copy. Corvilla has copies of all nutritional assessments now. A schedule was provided by the dietician for when she will be doing her annual assessments. The DCCQA will check for compliance based on those dates provided. ISP's will be included on the QIDP's checklist of documents. This checklist will be reviewed monthly by the Residential Director or DCCQA to ensure all items are current. All homes will be reviewed monthly.	
W 0196 Bldg. 00	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. 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 active treatment programs were consistently and aggressively implemented. Findings include:	W 0196	Staff was retrained on active treatment on 3-8-24 and again on 3-28-24. Active treatment will be observed by the manager and corrected if not occurring. Active treatment will also be checked during random observations by the QIDP, Residential Director, or	03/31/2024

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	Observations were conducted in the group home on 2/26/24 from 3:15 pm to 5:40 pm and on 2/27/24 from 5:40 am to 8:00 am. Clients #1, #2, and #3 were present in the home throughout the observation periods. 1. On 2/26/24 there were four Direct Support Professionals (DSPs) in the home. When client #1 arrived to the home, the table was already set for dinner, and the evening meal was prepared and put away in serving dishes in the refrigerator. Client #1 arrived to the group home at 3:30 pm. Client #1 was assisted down the steps of the van and into the home by a staff with a gait belt. Client #1 wore a shirt protector and chewed on it throughout the observation periods. At 3:44 pm, client #1 was sitting in a chair at the dining table alone. At 3:45 pm, DSP #2 began to put client #1's dining harness on. DSP #2 stated, "You have to take meds (medications) still, I guess we'll wait." From 3:45 pm to 4:30 pm, client #1 paced from the dining room to the living room. Client #1 was not encouraged to participate in any activities. At 4:31 pm, client #1 sat in a chair in the living room. Direct Support Professional (DSP) #2 sat in a chair in the living room and did not engage with client #1. There was a movie playing on the television depicting humans eating raw brains, deceased humans stored in freezers, and humans turning into zombies. Client #1 did not look at the television. At 4:42 pm, client #1 went into the dining room and sat down at the table. DSP #1 was in the dining room and did not engage with client #1. At 4:52 pm, client #1 sat at the dining table without activity. At 5:07 pm, DSP #1 warmed up the prepared food in the microwave and set the serving dishes on the table. DSP #5 put a cloth dining harness over client #1's chest and tied the shoulder straps to the top of her chair. DSP #5		DCCQA. Active treatment schedules are done for each person and staff were trained on 3-8-24 and 3-28-24. This is complete for all homes. Goals are checked for compliance by the DCCQA and when not completed the QIDP will initiate corrective action.	

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	tied the lower straps under her arms to the back of client #1's chair. The dining harness had Velcro and was designed to be positioned over the abdomen with straps going over the client's shoulders and securing with the Velcro closures. When asked about the Velcro closures, DSP #5 stated, "What is Velcro?" DSP #3 stated, "I think the Velcro doesn't work, so they just do it however to get it secured." Client #1 was provided hand over hand assistance to serve her own meal. Client #1 finished her meal at 5:30 pm. On 2/27/24 there were 3 staff and one house manager (HM) working in the home. At 5:40 am, client #1 was dressed and was pacing through the home. At 5:54 am, DSP #1 brushed client #1's hair then put the brush away. Client #1 was not encouraged to brush her own hair or to put the hair brush away. At 6:05 am, client #1 was sitting at the dining table without activity. At 6:35 am, client #1 stood up from the table and fell to the floor. DSP #4 assisted client #1 to her feet, and DSP #1 took client #1 to her bedroom to look for injuries. DSP #1 reported there were no noticeable injuries. HM #1 instructed DSP #4 to report the fall to an administrator. From 6:15 am to 7:15 am, client #1 paced from the living room to the dining room without activity. Staff did not attempt to engage client #1. At 7:22 am, client #1 received her medication. At 7:33 am, client #1 was pacing between the living room and the kitchen. At 7:57 am, DSP #4 served client #1's breakfast. Client #1 was not encouraged to serve her own meal. An observation was conducted in the facility owned and operated day program on 2/27/24 from 12:30 pm to 1:30 pm. Client #1 was present throughout the observation period. At 12:30 pm, client #1 was standing in a room alone, looking out the window. Client #1 made her way through			

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	the main activity room and into a storage closet. Client #1 was directed out of the storage room by staff. Client #1 wandered around the main activity room and smaller rooms throughout the observation period. Client #1 was not engaged in the whole group activity. Client #1 was not encouraged to participate in another activity. Client #1's record was reviewed on 2/28/24 at 12:23 pm. Client #1's record did not include an Individual Support Plan. Client #1's record did include the following goals for documentation: "Staff will assist [client #1] in getting dressed. Staff will prompt her through the routine of getting dressed including [client #1] assisting with putting her pants on. Praise all attempts. Staff will prepare medications. Staff will assist [client #1] to a private era (sic) to take her meds (med room or bedroom). Staff will remind [client #1] to sit up and may physically prompt her after asking permission if needed. Praise all attempts. Staff will be seated next to [client #1] during meals due to her being a choking risk. When eating, staff will remind [client #1] to take a drink. Staff will ensure drink is thick due to diet order. Praise all attempts. After [client #1] has changed clothes, staff will assist her in putting her clothing in a laundry hamper. This can be completed with verbal, gestural, and physical prompting. Praise all attempts. Practice daily. Staff will tell [client #1] it is time to brush her teeth. Staff will prepare toothbrush. Staff will prompt [client #1] going forward to open her mouth, etc. Praise all attempts." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "I don't know what activities [client #1] likes. She's a tough cookie. She likes to climb.			

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	She has some goals - socialization, dental, money, hygiene. She should be encouraged to help with daily household tasks. She can get her own plate and put it on the table. She can pour her own drink with hand over hand help. She could put her laundry into the washer as well. Staff should talk to her, guide her, try to get her towards an activity or to help with something." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "[Client #1] has been here since the 90's. She has very little interest in things. I've gotten her to play with a keyboard a little bit. She likes music. She likes to chew on things. She likes to sit by people, and they can try to talk to her. Staff should attempt to engage with her whether she responds or not. They should try different things. She likes to walk outside when it's nice or to even sit outside." Chief Operations Officer (COO) #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "[Client #1] likes to look at magazines, she chews on rags or bibs. She does like to sit out in the sun." 2. On 2/26/24 at 3:15 pm, the dining table was set for dinner, and the meal was prepared and stored in the refrigerator in serving dishes. At 3:40 pm, client #2 walked into the group home from the facility van without assistance. Without prompting, client #2 picked up a bag of lunch bags and carried them into the kitchen. Client #2 sat on the sofa without activity until 4:38 pm. At 4:38 pm, DSP #2 prompted client #2 for her medication. Client #2 walked into the bathroom, unrolled an entire roll of toilet paper, put the paper in the toilet, and flushed it. DSP #2 observed. Client #2 began to undress and DSP #2 stated,			

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	"She's not going to take her medicine before she gets a shower." DSP #2 shut the bathroom door. At 4:52 pm, client #2 left the bathroom and carried her dirty clothing to her bedroom. At 5:12 pm, client #2 served her own meal with hand over hand assistance. Client #2 finished eating at 5:30 pm. On 2/27/24 client #2 sat in the living room without activity until 7:51 am. At 7:51 am, client #2 went into the kitchen without prompting and got milk from the refrigerator. Client #2 poured milk and chocolate syrup into a cup and stirred it without assistance. Client #2 sat at the dining table until 7:57 am. Client #2 served her own meal with hand over hand assistance and ate her breakfast independently. Client #2's record was reviewed on 2/28/24 at 11:24 am and did not include an ISP. Client #2's record indicated the following goals: "Staff will ask [client #2] if she would like to go to the store. If she agrees, staff will help her make a purchase. Praise all attempts. At medication time, staff will ask [client #2] to get water. Staff can help with verbal and physical prompts. Praise all attempts. Staff will prompt [client #2] to put her dishes in the dishwasher after meals. Praise all attempts. Staff will let [client #2] know it is time for her teeth brushing. Staff will complete the physical aspects, [client #2] will tolerate. Praise all attempts. Staff will remind [client #2] to wipe her face after meals. Praise all attempts. During meals, staff will sit next to [client #2] and prompt her to take sips between bites. Praise all attempts." QIDP #1 was interviewed on 2/28/24 at 2:11 pm			

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CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	and stated, "[Client #2] likes to sort things. She likes different textures. She can help around the house. She likes to get her own clothes out in the morning. She's particular about how things are done. She likes to sort her clothes and things." QIDP #1 stated, "I don't know of any specific activities for her in the home. She could help with cooking, setting the table, and taking out the garbage. Staff should encourage her to help." QIDP #1 indicated she was not aware of activity supplies in the home. Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "[Client #2] can do laundry, fold laundry. She can take it from the washer and put it in the dryer. She likes crafts and puzzles. They should have those things in the house. She likes to color and draw. They used to keep activity supplies in a cabinet in the kitchen." COO #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "I'm less familiar with [client #2]. I know she loves chocolate milk. She likes to have her hair and nails done. She has some OCD (obsessive compulsive disorder) tendencies. Routine is good for her." COO #1 stated, "[Client #2] in particular would enjoy setting the table. There should be magazines and coloring things at the home. Any opportunity we have to engage them, any activity that is appropriate and enjoyable, we should be doing that. Staff should prompt and encourage them to engage." 3. On 2/26/24 at 3:30 pm, client #3 arrived to the group home on the facility van. DSPs #2 and #3 assisted client #3 to transfer from a seat to his wheelchair using a gait belt. Staff assisted client #3 into the home in his wheelchair and assisted him into a chair. Client #3 sat in the chair in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G636	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	living room without activity until the end of the observation period at 5:30 pm. Three of client #3's peers were in the living room and engaged with staff in counting and singing activities. Client #3 did not participate in the activities and was not encouraged to participate in other activities. Client #3 sat in the chair and repeatedly raised his ankle to his mouth and chewed on it. On 2/27/24 at 5:40 am, client #3 was sitting in a chair in the living room. At 7:05 am, client #3 was assisted to the medication room by HM #1. HM #1 and DSP #2 administered client #3's morning medications through his g-tube (gastrostomy tube). After taking his medications, client #3 returned to the living room where he sat in a chair until the end of the observation period at 8:00 am. Staff working in the home did not offer client #3 an activity or attempt to engage him. Client #3's record was reviewed on 2/27/24 at 2:50 pm and did not include an ISP. The whole house weekday schedule posted on the wall in the dining room and reviewed on 2/26/24 at 3:30 pm indicated the following: "5:00 am - 6:00 am: Client awake, clean, and dress. 6:00 am - 7:00 am: Med (medication) pass, breakfast preparation. 7:00 am - 7:30 am: Breakfast. 7:30 am - 8:00 am: Breakfast clean-up, oral hygiene. 8:00 am: Off to day program. 4:00 pm - 5:00 pm: Showers [clients #5 and #6], dinner preparation. 5:00 pm - 6:00 pm: Med pass, 2nd med check, shower [client #1]. 6:00 pm - 7:00 pm: Dinner, oral hygiene. 7:00 - 8:00 pm: Alternating showers [clients #2, #4, and #7]. 8:00 - 10:00 pm: Clients to bed, laundry."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G636	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	QIDP #1 was interviewed on 2/28/24 at 2:11 pm and stated, "[Client #3] has been in the hospital a lot of the time he's been with us. He gets excited when staff are working with him. He likes to play with his feet." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "Staff should be trying different things to engage with him." COO #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "[Client #3's] referral was not very accurate. We've been working to get his level of care done. He's higher medical needs than what we can handle. He should be transferring." DSP #4 was interviewed on 2/27/24 at 7:15 am and stated, "They never help with cooking. [Client #2] is the only one who could maybe get something in the fridge, and she can put her dishes in the sink." DSP #4 stated, "I don't know what [client #1's] goals are. [Client #2] can put her clothes on by herself. She can make her bed. [Client #3] is supposed to understand the word, 'Up.'" DSP #4 stated, "We document goals every day." DSP #1 was interviewed on 2/27/24 at 7:15 am and stated, "[Client #1] takes her clothes to the wash and puts them in. [Client #2] is supposed to purchase something." 9-3-4(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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G636	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	to supplement the preliminary evaluation conducted prior to admission. Based on observation, record review, and interview for 1 of 3 sample clients (#3), the facility failed to ensure client #3 had a Comprehensive Functional Assessment (CFA) completed within 30 days of admission. Findings include: Client #3's record was reviewed on 2/27/24 at 2:50 pm and indicated an admission date of 10/7/23. Client #3's record did not include a CFA. Client #3's record indicated he did not have an advocate or guardian. Client #3's record indicated a history of injuries caused by falls from seizures as well attempting to walk without assistance. Observations were conducted on 2/26/24 from 3:15 pm to 5:40 pm and on 2/27/24 from 5:40 am to 8:00 am. Client #3 was present in the home throughout the observation periods. Client #3 used a wheelchair with a seatbelt for ambulation and a gait belt for transfers. Client #3 rocked back and forth and from side to side and tipped his wheelchair from side to side and slid it backwards when the brakes were applied. Client #3 did not communicate verbally with staff and peers and did not show recognition of their verbal interactions and physical prompts. Client #3 used a g-tube (gastrostomy tube) for all intake. Client #3 used adult briefs and did not toilet independently. Client #3 required staff assistance for all facets of his daily life. Client #3 sat in a chair in the living room and on the floor on a mat and chewed on his ankle. Client #3 did not engage in any activity. Qualified Intellectual Disabilities Professional	W 0210	The missing CFA was completed and reviewed on March 11, 2024. All CFA's at all homes were reviewed for compliance. The Residential Director or DCCQA will review CFA"s annually for compliance or within 30 days of a new admission or if changes are warranted throughout the year. The QIDP has a tracking sheets for all needed items including CFA's. This checklist will be reviewed monthly by the Residential Director or DCCQA.	03/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G636	A. BUILDING 00 B. WING	03/07/2024

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CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	(QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "I have not done a CFA. It should have been completed in the first 30 days." QIDP #1 stated, "[Client #3] does not have a guardian. He is not able to make decisions for himself. I think he does need a guardian or representative. I have not done an assessment." Chief Operations Officer (COO) #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "The CFA should be completed within 30 days of him moving in." 9-3-4(a)			
W 0217 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include nutritional status. Based on record review and interview for 2 of 3 sample clients (#1 and #2), the facility failed to ensure clients #1 and #2 had nutrition assessments completed. Findings include: 1. Client #1's record was reviewed on 2/28/24 at 12:23 pm and indicated an admission date of 1/15/93. Client #1's dining plan dated July 2023 indicated her meal should be pureed, and she should have a shirt protector, a coated, built up spoon, a dining harness, and a scoop plate. Client #1's record did not include a nutritional assessment. 2. Client #2's record was reviewed on 2/28/24 at 11:24 am and indicated an admission date of 1/3/14. Client #2's dining plan dated July 2023	W 0217	The nutritional assessment was completed. The dietician provided a copy. Corvilla has copies of all nutritional assessments now. A schedule was provided by the dietician for when she will be doing her annual assessments. The DCCQA will check for compliance based on those dates provided.	03/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G636	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	indicated her meal texture should be mechanical soft. Client #2's record did not include a nutritional assessment. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "The nutritional assessment should be done every year." QIDP #1 stated, "[Client #1] should have a nutrition assessment. We are concerned about her weight not staying up." 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 1 of 3 sample clients (#3), the facility failed to develop an Individual Support Plan (ISP) for client #3 within 30 days of admission to the group home. Findings include: Client #3's record was reviewed on 2/27/24 at 2:50 pm and indicated an admission date of 10/7/23. Client #3's record did not include an ISP. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "[Client #3] doesn't have an ISP. I couldn't find it. He does have goals." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "The ISP should be	W 0226	ISP's will be included on the QIDP's checklist of documents. This checklist will be reviewed monthly by the Residential Director or DCCQA to ensure all items are current. There is also a 30-day new intake checklist of items needed completed which includes the ISP meeting and ISP document. The Residential Director will review all intakes for completion. All homes will be reviewed monthly. All ISP's since the survey have occurred and are documented.	03/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G636	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	created within 30 days of admission." Chief Operations Officer (COO) #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "There should be an ISP, and it should be available." 9-3-4(a)			
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 client (#1, #2, and #3), the facility failed to effectively implement clients #1, #2, and #3's active treatment programs at all opportunities. Findings include: Observations were conducted in the group home on 2/26/24 from 3:15 pm to 5:40 pm and on 2/27/24 from 5:40 am to 8:00 am. Clients #1, #2, and #3 were present in the home throughout the observation periods. 1. On 2/26/24 there were four Direct Support Professionals (DSPs) in the home. When client #1 arrived to the home, the table was already set for dinner, and the evening meal was prepared and put away in serving dishes in the refrigerator. Client #1 arrived to the group home at 3:30 pm.	W 0249	Staff was retrained on active treatment on 3-8-24 and again on 3-28-24 including teachable moments, natural time to complete goals and engaging the individuals in all that staff does to the best of their abilities. Refusals by clients will be documented. Staff will attempt multiple times before documenting a refusal. Active treatment will be observed by the manager and corrected if not occurring. Active treatment will also be checked during random observations by the QIDP, Residential Director, or DCCQA. Active treatment schedules are done for each person and staff were trained on 3-8-24 and 3-28-24. This is complete for all homes. Goals are checked for	03/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G636	A. BUILDING 00 B. WING	03/07/2024

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	Client #1 was assisted down the steps of the van and into the home by a staff with a gait belt. Client #1 wore a shirt protector and chewed on it throughout the observation periods. At 3:44 pm, client #1 was sitting in a chair at the dining table alone. At 3:45 pm, DSP #2 began to put client #1's dining harness on. DSP #2 stated, "You have to take meds (medications) still, I guess we'll wait." From 3:45 pm to 4:30 pm, client #1 paced from the dining room to the living room. Client #1 was not encouraged to participate in any activities. At 4:31 pm, client #1 sat in a chair in the living room. Direct Support Professional (DSP) #2 sat in a chair in the living room and did not engage with client #1. There was a movie playing on the television depicting humans eating raw brains, deceased humans stored in freezers, and humans turning into zombies. Client #1 did not look at the television. At 4:42 pm, client #1 went into the dining room and sat down at the table. DSP #1 was in the dining room and did not engage with client #1. At 4:52 pm, client #1 sat at the dining table without activity. At 5:07 pm, DSP #1 warmed up the prepared food in the microwave and set the serving dishes on the table. DSP #5 put a cloth dining harness over client #1's chest and tied the shoulder straps to the top of her chair. DSP #5 tied the lower straps under her arms to the back of client #1's chair. The dining harness had Velcro and was designed to be positioned over the abdomen with straps going over the client's shoulders and securing with the Velcro closures. When asked about the Velcro closures, DSP #5 stated, "What is Velcro?" DSP #3 stated, "I think the Velcro doesn't work, so they just do it however to get it secured." Client #1 was provided hand over hand assistance to serve her own meal. Client #1 finished her meal at 5:30 pm. On 2/27/24 there were 3 staff and one house		compliance by the DCCQA and when not completed the QIDP will initiate corrective action.	

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	15G636	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	manager (HM) working in the home. At 5:40 am, client #1 was dressed and was pacing through the home. At 5:54 am, DSP #1 brushed client #1's hair then put the brush away. Client #1 was not encouraged to brush her own hair or to put the hair brush away. At 6:05 am, client #1 was sitting at the dining table without activity. At 6:35 am, client #1 stood up from the table and fell to the floor. DSP #4 assisted client #1 to her feet, and DSP #1 took client #1 to her bedroom to look for injuries. DSP #1 reported there were no noticeable injuries. HM #1 instructed DSP #4 to report the fall to an administrator. From 6:15 am to 7:15 am, client #1 paced from the living room to the dining room without activity. Staff did not attempt to engage client #1. At 7:22 am, client #1 received her medication. At 7:33 am, client #1 was pacing between the living room and the kitchen. At 7:57 am, DSP #4 served client #1's breakfast. Client #1 was not encouraged to serve her own meal. An observation was conducted in the facility owned and operated day program on 2/27/24 from 12:30 pm to 1:30 pm. Client #1 was present throughout the observation period. At 12:30 pm, client #1 was standing in a room alone, looking out the window. Client #1 made her way through the main activity room and into a storage closet. Client #1 was directed out of the storage room by staff. Client #1 wandered around the main activity room and smaller rooms throughout the observation period. Client #1 was not engaged in the whole group activity. Client #1 was not encouraged to participate in another activity. Client #1's record was reviewed on 2/28/24 at 12:23 pm. Client #1's record did not include an Individual Support Plan. Client #1's record did include the following goals for documentation: "Staff will assist [client #1] in getting dressed.			

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	15G636	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	Staff will prompt her through the routine of getting dressed including [client #1] assisting with putting her pants on. Praise all attempts. Staff will prepare medications. Staff will assist [client #1] to a private era (sic) to take her meds (med room or bedroom). Staff will remind [client #1] to sit up and may physically prompt her after asking permission if needed. Praise all attempts. Staff will be seated next to [client #1] during meals due to her being a choking risk. When eating, staff will remind [client #1] to take a drink. Staff will ensure drink is thick due to diet order. Praise all attempts. After [client #1] has changed clothes, staff will assist her in putting her clothing in a laundry hamper. This can be completed with verbal, gestural, and physical prompting. Praise all attempts. Practice daily. Staff will tell [client #1] it is time to brush her teeth. Staff will prepare toothbrush. Staff will prompt [client #1] going forward to open her mouth, etc. Praise all attempts." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "I don't know what activities [client #1] likes. She's a tough cookie. She likes to climb. She has some goals - socialization, dental, money, hygiene. She should be encouraged to help with daily household tasks. She can get her own plate and put it on the table. She can pour her own drink with hand over hand help. She could put her laundry into the washer as well. Staff should talk to her, guide her, try to get her towards an activity or to help with something." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "[Client #1] has been here since the 90's. She has very little			

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	15G636	A. BUILDING 00 B. WING	03/07/2024

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CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	interest in things. I've gotten her to play with a keyboard a little bit. She likes music. She likes to chew on things. She likes to sit by people, and they can try to talk to her. Staff should attempt to engage with her whether she responds or not. They should try different things. She likes to walk outside when it's nice or to even sit outside." Chief Operations Officer (COO) #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "[Client #1] likes to look at magazines, she chews on rags or bibs. She does like to sit out in the sun." 2. On 2/26/24 at 3:15 pm, the dining table was set for dinner, and the meal was prepared and stored in the refrigerator in serving dishes. At 3:40 pm, client #2 walked into the group home from the facility van without assistance. Without prompting, client #2 picked up a bag of lunch bags and carried them into the kitchen. Client #2 sat on the sofa without activity until 4:38 pm. At 4:38 pm, DSP #2 prompted client #2 for her medication. Client #2 walked into the bathroom, unrolled an entire roll of toilet paper, put the paper in the toilet, and flushed it. DSP #2 observed. Client #2 began to undress and DSP #2 stated, "She's not going to take her medicine before she gets a shower." DSP #2 shut the bathroom door. At 4:52 pm, client #2 left the bathroom and carried her dirty clothing to her bedroom. At 5:12 pm, client #2 served her own meal with hand over hand assistance. Client #2 finished eating at 5:30 pm. On 2/27/24 client #2 sat in the living room without activity until 7:51 am. At 7:51 am, client #2 went into the kitchen without prompting and got milk from the refrigerator. Client #2 poured milk and chocolate syrup into a cup and stirred it without			

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	15G636	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	assistance. Client #2 sat at the dining table until 7:57 am. Client #2 served her own meal with hand over hand assistance and ate her breakfast independently. Client #2's record was reviewed on 2/28/24 at 11:24 am and did not include an ISP. Client #2's record indicated the following goals: "Staff will ask [client #2] if she would like to go to the store. If she agrees, staff will help her make a purchase. Praise all attempts. At medication time, staff will ask [client #2] to get water. Staff can help with verbal and physical prompts. Praise all attempts. Staff will prompt [client #2] to put her dishes in the dishwasher after meals. Praise all attempts. Staff will let [client #2] know it is time for her teeth brushing. Staff will complete the physical aspects, [client #2] will tolerate. Praise all attempts. Staff will remind [client #2] to wipe her face after meals. Praise all attempts. During meals, staff will sit next to [client #2] and prompt her to take sips between bites. Praise all attempts." QIDP #1 was interviewed on 2/28/24 at 2:11 pm and stated, "[Client #2] likes to sort things. She likes different textures. She can help around the house. She likes to get her own clothes out in the morning. She's particular about how things are done. She likes to sort her clothes and things." QIDP #1 stated, "I don't know of any specific activities for her in the home. She could help with cooking, setting the table, and taking out the garbage. Staff should encourage her to help." QIDP #1 indicated she was not aware of activity supplies in the home. Director of Corporate Compliance and Quality			

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	15G636	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "[Client #2] can do laundry, fold laundry. She can take it from the washer and put it in the dryer. She likes crafts and puzzles. They should have those things in the house. She likes to color and draw. They used to keep activity supplies in a cabinet in the kitchen." COO #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "I'm less familiar with [client #2]. I know she loves chocolate milk. She likes to have her hair and nails done. She has some OCD (obsessive compulsive disorder) tendencies. Routine is good for her." COO #1 stated, "[Client #2] in particular would enjoy setting the table. There should be magazines and coloring things at the home. Any opportunity we have to engage them, any activity that is appropriate and enjoyable, we should be doing that. Staff should prompt and encourage them to engage." 3. On 2/26/24 at 3:30 pm, client #3 arrived to the group home on the facility van. DSPs #2 and #3 assisted client #3 to transfer from a seat to his wheelchair using a gait belt. Staff assisted client #3 into the home in his wheelchair and assisted him into a chair. Client #3 sat in the chair in the living room without activity until the end of the observation period at 5:30 pm. Three of client #3's peers were in the living room and engaged with staff in counting and singing activities. Client #3 did not participate in the activities and was not encouraged to participate in other activities. Client #3 sat in the chair and repeatedly raised his ankle to his mouth and chewed on it. On 2/27/24 at 5:40 am, client #3 was sitting in a chair in the living room. At 7:05 am, client #3 was assisted to the medication room by HM #1. HM #1 and DSP #2 administered client #3's morning			

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	medications through his g-tube (gastrostomy tube). After taking his medications, client #3 returned to the living room where he sat in a chair until the end of the observation period at 8:00 am. Staff working in the home did not offer client #3 an activity or attempt to engage him. Client #3's record was reviewed on 2/27/24 at 2:50 pm and did not include an ISP. QIDP #1 was interviewed on 2/28/24 at 2:11 pm and stated, "[Client #3] has been in the hospital a lot of the time he's been with us. He gets excited when staff are working with him. He likes to play with his feet." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "Staff should be trying different things to engage with him." COO #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "[Client #3's] referral was not very accurate. We've been working to get his level of care done. He's higher medical needs than what we can handle. He should be transferring." DSP #4 was interviewed on 2/27/24 at 7:15 am and stated, "They never help with cooking. [Client #2] is the only one who could maybe get something in the fridge, and she can put her dishes in the sink." DSP #4 stated, "I don't know what [client #1's] goals are. [Client #2] can put her clothes on by herself. She can make her bed. [Client #3] is supposed to understand the word, 'Up.'" DSP #4 stated, "We document goals every day." DSP #1 was interviewed on 2/27/24 at 7:15 am and stated, "[Client #1] takes her clothes to the wash and puts them in. [Client #2] is supposed to			

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	purchase something." 9-3-4(a)			
W 0260 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on record review and interview for 2 of 3 sample clients (#1 and #2), the facility failed to ensure clients #1 and #2 had Individual Support Plans (ISPs). Findings include: 1. Client #1's record was reviewed on 2/28/24 at 12:23 pm and indicated an admission date of 1/15/1993. Client #1's record did not include an ISP. 2. Client #2's record was reviewed on 2/28/24 at 11:25 am and indicated an admission date of 1/3/2014. Client #2's record did not include an ISP. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "I couldn't find their ISPs. They would have been done last year in 2023. I couldn't find the paper work for the meetings. They should be done every year with updates as needed." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "ISPs should be in their files."	W 0260	ISP's will be included on the QIDP's checklist of documents. This checklist will be reviewed monthly by the Residential Director or DCCQA to ensure all items are current. There is also a 30-day new intake checklist of items needed completed which includes the ISP meeting and ISP document. The Residential Director will review all intakes for completion. All homes will be reviewed monthly. All ISP's since the survey have occurred and are documented.	03/31/2024

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	Chief Operations Officer (COO) #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "ISPs should be available. There should be a paper copy, and it should be on [digital record keeping system]." 9-3-4(a)			
W 0312 Bldg. 00	483.450(e)(2) DRUG USAGE be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 3 sample clients (#2), the facility failed to develop a Behavior Support Plan (BSP) to address client #2's maladaptive behaviors. Findings include: Client #2's record was reviewed on 2/28/24 at 11:24 am. Client #2's physician order for February 2024 indicated the following medications: "Ziprasidone 40 mg (milligram) cap (capsule) take 1 capsule by mouth every evening with meals for aggression. Clomipramine 25 mg capsule, take 1 capsule by mouth every morning and 2 capsules by mouth every night at bedtime for OCD (obsessive compulsive disorder)." Client #2's record indicated she was prescribed one medication for aggression and one for OCD behaviors. Client #2's record did not include a BSP to address her identified maladaptive behaviors.	W 0312	The BSP was completed for the person missing one. All homes were reviewed for any missing BSP's. Staff were trained on this BSP on 3-28-2024. The QIDP has a checklist of all BSP's and when they are due. The DCCQA or Residential Director will review monthly to ensure compliance.	03/31/2024

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	Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "[Client #2] does not have a behavior plan. She should have a plan if she has medications for behaviors." Director of Corporate Compliance and Quality Assurance #1 was interviewed on 2/29/24 at 10:30 am and stated, "[Client #2] should have a behavior plan if there is a medication for aggression." 9-3-5(a)			
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 sample clients (#3), the facility failed to ensure client #3 had vision and hearing exams completed within 30 days of admission. Findings include: Client #3's record was reviewed on 2/27/24 at 2:50 pm and indicated an admission date of 10/7/23. Client #3's record did not include documentation of hearing or vision exams within 30 days of his admission to the group home. Health and Wellness Coordinator #1 was interviewed by phone on 2/29/24 at 12:41 pm and stated, "I did schedule the vision, but we had to cancel due to him being in the hospital in December. I have it scheduled for April 24th. I have not gotten a hearing exam scheduled. We	W 0323	The nurse will ensure all appointments are completed. If the person misses an appointment, it will be immediately rescheduled and documented why it was missed. All new admissions will have their appointments completed or scheduled within 30 days of admission. The residential Director will ensure compliance and review the new admission checklist for these items.	03/31/2024

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	are searching for a new audiologist." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "Vision and hearing assessments should be done within the first 30 days." 9-3-6(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 sample clients (#3), the facility's nursing services failed to ensure client #3's health needs were met. Findings include: Client #3's record was reviewed on 2/27/24 at 2:50 pm and indicated an admission date of 10/7/23. The facility's Bureau of Disabilities Services (BDS) reports and related investigations were reviewed on 2/27/24 at 11:50 am. 1. A BDS report written by the agency nurse and dated 10/19/23 indicated the following: "Today at day program, agency nurse went to get vitals on a (sic) [client #3] to complete an assessment when it was discovered a large bruise/lump measuring more than 6 inches in length and 2 inches wide on the right side of scalp, smaller bruise measuring about 2 inches in length wrapping around behind the right ear. Both areas appear bright red and purple in color. [Client #3's] vitals were out of range with bp (blood pressure) and pulse being high, pupils not dilating, and [client #3] appeared more tired than usual. House Manager was notified that agency	W 0331	All discharge orders will be reviewed by the nurse and the nurse is responsible to ensure staff complete any follow-up appointments and obtain follow-up medications. Going forward, the DCCQA will receive discharge orders as well and will work with the nursing staff to ensure all follow-up appointments are completed and medications received. This will ensure the DCCQA will know if appointments are not completed, and an IR can be filed for neglect and staff disciplined. Any wrong medications administered upon knowledge will continue to be reported as required. Any delays with the pharmacy in obtaining medications will be documented. All staff were retrained that any discrepancies between he MAR and the medication label are to be addressed at once with the nurse. This incident was investigated and reported, and staff received	03/31/2024

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	nurse was sending [client #3] to the ER (emergency room) via ambulance. House Manager was asked if he had seen a bruise on [client #3's] scalp on Wednesday (10/18/23). Manager stated that he did not have any bruising last night when showered exception (sic) for the inside of right ear from a fall earlier this week (10/16/23) that showed up this week on Wednesday (10/18/23).... [Client #3] arrived at the ER, and staff met him there. While at the ER, CT (computerized tomography) scan of neck/head and x-ray ordered and completed. No abnormal findings. Labs were ordered and completed, and labs showed [client #3's] sodium was depleted. [Client #3] was admitted to the hospital." Client #3's hospital discharge orders dated 10/20/23 indicated the following: "He should have repeat BMP (Basic Metabolic Panel) on Monday 10/23/23 to reevaluate his sodium with results to his PCP (primary care physician)." Client #3's hospital discharge orders dated 10/20/23 indicated a prescription for Sodium Chloride (salt)1 g (gram) twice daily." Client #3's record did not indicate a follow up BMP on 10/23/23. Client #3's Medication Administration Record (MAR) for October 2023 indicated he did not receive sodium chloride until 10/30/23. 2. A BDS report written by the agency nurse and dated 10/25/23 indicated the following occurred on 10/24/23: "Staff alerted nurse to new bruising on [client #3's] shoulders. Upon investigating, it was noted by nurse that [client #3] had a new lump on the right side of scalp, slightly below the current bruise he has. It appeared that it had dry blood		corrective action. The Nursing staff were retrained that the MAR and labels need to match and if is a question, ask immediately.	

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	present, no active bleeding. Staff let nurse know that [client #3's] nose was bleeding on and off, and he appeared to be more tired than usual. [Client #3] does have a history of nose bleeds, but, due to the new lump, agency nurse did not want to chance it. [Client #3] was sent out to the ER via ambulance. Staff met [client #3] at the ER, and, once at the ER, doctor ordered and completed labs and a CT scan. CT scan was normal. Blood work showed that [client #3's] sodium was again depleted. Staff asked about bruises, and the nurse stated that all the bruises seem old and in various stages of healing. The hematoma on (sic) head was also stated by nurse that it appears that it was caused by the recent fall he had the prior week (10/16/23). Doctor believes one of [client #3's] seizures (sic) medications may be the cause of his sodium depletion. [Client #3] was admitted for more testing." Client #3's hospital record indicated the following physician note on 10/24/23: "Labs here reveal a sodium of 120 which was lower than his last admission. He does not have a med administration record with him. I cannot see that the salt tabs were filled, however, they may have gotten them from an outside pharmacy. Due to his critical hyponatremia, admission is required. I called and updated his father. He states the patient had been fairly well controlled with a seizure until he recently moved to the group home. There have been some miscommunication on his medications, and so he started having breakthrough seizures again.... His parents are aware of low sodium levels in the past, however, it is unknown to them what was done about it." Client #3's hospital record indicated the following physician note on 10/26/23: "[Client #3] was found to have severe			

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	hyponatremia and was admitted for work-up and treatment. He was given a liter of saline and restarted on salt tabs. His sodium rapidly normalized. I spoke with his nurse at this group home, and she was unaware that he was to be initiated on salt tabs after his last hospitalization. I faxed her the prescription for the salt tabs. Patient was back to baseline and will be discharged back to his group home in stable condition." Client #3's record indicated he was discharged from the group home on 10/26/23 with a prescription for sodium chloride 1 g twice daily. Client #3's MAR for October 2023 indicated he did not receive sodium chloride until 10/30/23. 3. A BDS report dated 11/29/23 indicated the following: "On 11/29/23 it was discovered that the pharmacy sent the wrong medication for [client #3]. [Client #3] is prescribed Sodium Chloride 1 mg (milligram) (sic) twice per day. The pharmacy sent Sodium Bicarbonate (antacid) 650 mg twice per day. The wrong medication had been given since 11/22/2023 which totals 13 doses. The correct medication, Sodium Chloride was picked up today and will start tonight. [Client #3's] PCP was notified of the error." An investigation dated 12/1/23 indicated the following: "Staff should not have been giving the medication as what was on the card did not match the MAR and doctor's order. Staff did not follow the medication administration policy and did not complete compliance checks three times before passing the medication, ensuring the medication card and MAR match. When they don't match, they should not administer the medication and			

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	contact the nurse immediately. The pharmacy also made a mistake in their packing and compliance checks." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "There should be a collaborative effort between the health and wellness coordinator and the nurse to ensure medications are given. The QIDP should be aware of medication changes. The ideal is to have the prescription and medications in the home when the client returns from the hospital. Sometimes the procedure is impossible to implement. The nurse should have been aware of the medication change." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "I know his sodium was depleted, that's why he was in the hospital on the 19th. The nurse would be responsible for making sure the new medication was available." Health and Wellness Coordinator (HWC) #1 was interviewed by phone on 2/29/24 at 12:41 pm and stated, "Usually, the nurse should look at the discharge summary before they are discharged. The nurse should review the level of care and any new prescriptions, we have to try to have everything in place prior to discharge. We try to make sure, the day before discharge, they are sending the instructions over, so they can be reviewed. The nurse should have checked to make sure the prescription was ready to go before [client #3] arrived home." HWC #1 stated, "I picked up the sodium bicarbonate. The pharmacy said, 'Yes, that's what he has ordered.' I inquired of the doctor, and he said, 'That's not the right medication.' The pharmacy was doing an investigation of why it			

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	happened. It should have been caught when they were filling it. I thought it was a change on the name, not realizing it was the wrong medication. I directed staff to change the MAR and write it in as sodium bicarbonate." The facility's nursing staff was not available for interview at the time of the survey. 9-3-6(a)			
W 0351 Bldg. 00	483.460(f)(1) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). Based on record review and interview for 1 of 3 sample clients (#3), the facility failed to ensure client #3 had a dental exam completed within 30 days of admission. Findings include: Client #3's record was reviewed on 2/27/24 at 2:50 pm and indicated an admission date of 10/7/23. Client #3's record did not include documentation of a dental exam within 30 days of his admission to the group home. Health and Wellness Coordinator #1 was interviewed by phone on 2/29/24 at 12:41 pm and stated, "His dental is scheduled for April 10th. We haven't been able to get him in. We've been scheduling 6 to 7 months out."	W 0351	The nurse will ensure all appointments are completed. If the person misses an appointment, it will be immediately rescheduled and documented why it was missed. All new admissions will have their appointments completed or scheduled within 30 days of admission. The residential Director will ensure compliance and review the new admission checklist for these items.	03/31/2024

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	Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "Dental exams should be completed within 30 days of admission." 9-3-6(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record and interview for 1 of 3 sample clients (#3), the facility failed to ensure client #3's medication was administered according to physician's orders. Findings include: Client #3's record was reviewed on 2/27/24 at 2:50 pm and indicated an admission date of 10/7/23. The facility's Bureau of Disabilities Services (BDS) reports and related investigations were reviewed on 2/27/24 at 11:50 am. 1. A BDS report written by the agency nurse and dated 10/19/23 indicated client #3 was admitted to the hospital due to a sodium deficiency. Client #3's hospital discharge orders dated 10/20/23 indicated the following: "He should have repeat BMP (Basic Metabolic Panel) on Monday 10/23/23 to reevaluate his sodium with results to his PCP (primary care physician)." Client #3's hospital discharge orders dated 10/20/23 indicated a prescription for Sodium	W 0368	All discharge orders will be reviewed by the nurse and the nurse is responsible to ensure staff complete any follow-up appointments and obtain follow-up medications. Going forward, the DCCQA will receive discharge orders as well and will work with the nursing staff to ensure all follow-up appointments are completed and medications received. This will ensure the DCCQA will know if appointments are not completed, and an IR can be filed for neglect and staff disciplined. Any wrong medications administered upon knowledge will continue to be reported as required. Any delays with the pharmacy in obtaining medications will be documented. All staff were retrained that any discrepancies between he MAR and the medication label are to be addressed at once with the nurse. This incident was investigated and reported, and staff received	03/31/2024

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	Chloride (salt)1 g (gram) twice daily." Client #3's record did not indicate a follow up BMP on 10/23/23. Client #3's Medication Administration Record (MAR) for October 2023 indicated he did not receive sodium chloride until 10/30/23. 2. A BDS report written by the agency nurse and dated 10/25/23 indicated client #3 was admitted to the hospital due to a sodium deficiency on 10/24/23. Client #3's hospital record indicated the following physician note on 10/24/23: "Labs here reveal a sodium of 120 which was lower than his last admission. He does not have a med administration record with him. I cannot see that the salt tabs were filled, however, they may have gotten them from an outside pharmacy. Due to his critical hyponatremia, admission is required. I called and updated his father. He states the patient had been fairly well controlled with a seizure until he recently moved to the group home. There have been some miscommunication on his medications, and so he started having breakthrough seizures again.... His parents are aware of low sodium levels in the past, however, it is unknown to them what was done about it." Client #3's hospital record indicated the following physician note on 10/26/23: "[Client #3] was found to have severe hyponatremia and was admitted for work-up and treatment. He was given a liter of saline and restarted on salt tabs. His sodium rapidly normalized. I spoke with his nurse at this group home, and she was unaware that he was to be initiated on salt tabs after his last hospitalization. I faxed her the prescription for the salt tabs.		corrective action. The Nursing staff were retrained that the MAR and labels need to match and if is a question, ask immediately.	

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	15G636	A. BUILDING 00 B. WING	03/07/2024

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	Patient was back to baseline and will be discharged back to his group home in stable condition." Client #3's record indicated he was discharged from the group home on 10/26/23 with a prescription for sodium chloride 1 g twice daily. Client #3's MAR for October 2023 indicated he did not receive sodium chloride until 10/30/23. 3. A BDS report dated 11/29/23 indicated the following: "On 11/29/23 it was discovered that the pharmacy sent the wrong medication for [client #3]. [Client #3] is prescribed Sodium Chloride 1 mg (milligram) (sic) twice per day. The pharmacy sent Sodium Bicarbonate (antacid) 650 mg twice per day. The wrong medication had been given since 11/22/2023 which totals 13 doses. The correct medication, Sodium Chloride was picked up today and will start tonight. [Client #3's] PCP was notified of the error." An investigation dated 12/1/23 indicated the following: "Staff should not have been giving the medication as what was on the card did not match the MAR and doctor's order. Staff did not follow the medication administration policy and did not complete compliance checks three times before passing the medication, ensuring the medication card and MAR match. When they don't match, they should not administer the medication and contact the nurse immediately. The pharmacy also made a mistake in their packing and compliance checks." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "There should be a collaborative effort			

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	between the health and wellness coordinator and the nurse to ensure medications are given. The QIDP should be aware of medication changes. The ideal is to have the prescription and medications in the home when the client returns from the hospital. Sometimes the procedure is impossible to implement. The nurse should have been aware of the medication change." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "I know his sodium was depleted, that's why he was in the hospital on the 19th. The nurse would be responsible for making sure the new medication was available." Health and Wellness Coordinator (HWC) #1 was interviewed by phone on 2/29/24 at 12:41 pm and stated, "Usually, the nurse should look at the discharge summary before they are discharged. The nurse should review the level of care and any new prescriptions, we have to try to have everything in place prior to discharge. We try to make sure, the day before discharge, they are sending the instructions over, so they can be reviewed. The nurse should have checked to make sure the prescription was ready to go before [client #3] arrived home." HWC #1 stated, "I picked up the sodium bicarbonate. The pharmacy said, 'Yes, that's what he has ordered.' I inquired of the doctor, and he said, 'That's not the right medication.' The pharmacy was doing an investigation of why it happened. It should have been caught when they were filling it. I thought it was a change on the name, not realizing it was the wrong medication. I directed staff to change the MAR and write it in as sodium bicarbonate." The facility's nursing staff was not available for			

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	interview at the time of the survey. 9-3-6(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 ensure client #6's prescribed medications were administered without error. Findings include: An observation was conducted in the group home on 2/27/24 from 5:40 am to 8:00 am. Client #6 was present in the home throughout the observation period. On 2/27/24 at 6:06 am, Direct Support Professional (DSP) #2 assisted client #6 to the medication room and prepared and administered his medications. At 6:29 am, DSP #2 assisted client #6 to the living room and indicated she was ready for the next medication administration. Client #6's Medication Administration Record (MAR) dated February 2024 was reviewed on 2/27/24 at 6:40 am and indicated the following medication was prescribed at 7:00 am. "Phenobarbital (used to prevent seizures) 16.2 mg (milligrams). Tramadol (used to treat pain) 50 mg." DSP #2 indicated she did not administer client #6's Phenobarbital and Tramadol. At 6:29 am, DSP #2	W 0369	All staff were retrained in Medication Administration on 3-8-2024 and 3-28-24. The six rights of medication administration was reviewed, and each person performed a mock medication administration. Staff were also retrained in closing the door for privacy and locking the door when leaving the med area. Staff committing medication errors receive corrective action and retraining if required. Staff will be observed at medication administration during random observations by the management team at all homes.	03/31/2024

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	stated, "He's supposed to have them. I forgot to give him his controlled medication." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "[Client #6's] medication should be administered as prescribed. It is a medication error." Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "Medications should be given as prescribed." Health and Wellness Coordinator #1 was interviewed by phone on 2/29/24 at 12:41 pm and stated, "Medications should be passed according to the physician orders." Chief Operations Officer (COO) #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "It is a medication error." 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 stored in a secure location when not in use. Findings include:	W 0382	All staff were retrained in Medication Administration on 3-8-2024 and 3-28-24. The six rights of medication administration was reviewed, and each person performed a mock medication administration. Staff were also retrained in closing the door for privacy and locking the door when leaving the med area. Staff	03/31/2024

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	Observations were conducted in the group home on 2/26/24 from 3:40 pm to 5:30 pm and on 2/27/24 from 5:40 am to 8:00 am. Clients #1, #2, #3, #4, #5, #6, and #7 were present in the home throughout the observation period. On 2/26/24 at 3:40 pm, the surveyor was greeted at the group home by Direct Support Professional (DSP) #1. DSP #1 indicated the clients had not arrived home from day program, and she was the only person in the home. DSP #1 indicated she was preparing the evening meal and was in the kitchen. The medication room door was standing open. Medications were stored in baskets on unsecured shelves. Controlled medications were stored in a metal box with a lock. Clients #1, #2, #3, #4, #5, #6, and #7 arrived to the home at 3:50 pm. The medication room door remained open until 3:48 pm when DSP #3 began a medication pass. On 2/27/24 at 6:06 am, DSP #2 was in the medication preparing for a medication pass. DSP #2 put gloves on and left the medication room door open while she went to the living room to get client #6. DSP #2 assisted client #6 to the medication room. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "The medications should be behind a locked door. Controlled medications should be behind two locks at all times." Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "The medication door should be closed and locked when no staff are in there." Health and Wellness Coordinator #1 was		committing medication errors receive corrective action and retraining if required. Staff will be observed at medication administration during random observations by the management team at all homes.	

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	interviewed by phone on 2/29/24 at 12:41 pm and stated, "Medications are locked up behind a door. The door should be closed and locked when meds (medications) are not being passed." Chief Operations Officer (COO) #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "Medications should be locked in the med room." 9-3-6(a)			
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS at least quarterly for each shift of personnel. Based on record review 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 participated in evacuation drills at least once per quarter for each shift of personnel. Findings include: Clients #1, #2, #3, #4, #5, #6, and #7's evacuation drills were reviewed on 2/27/24 at 11:37 am and indicated the following: 1st quarter: Day shift (7:00 am to 3:00 pm): 1/19/24 at 2:35 pm, 2/16/23 at 12:37 pm. Evening shift (3:00 pm to 11:00 pm): 3/8/23, 10:00 pm. The review did not indicate any evacuation drills were run on the night shift (11:00 pm to 7:00 am) in the first quarter of 2023 and 2024. 2nd quarter: Day shift: 6/8/23, 7:10 am. Evening shift: 4/24/23, 8:40 pm, 5/13/23, 6:00 pm.	W 0440	All evacuation drills are current for 2024 at all 4 homes. The DCCQA tracks these drills and reminds the manager on the 15th of each month if not completed. Corrective action will occur if not completed on time. Fire drills are tracked by the DCCQA. All drills are completed for 2024 by all four homes. The DCCQA reminds managers each month what drill is needed as well as providing them an annual list of drills and what is needed each month.	03/31/2024

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	The review did not indicate any evacuation drills were run on the night shift in the second quarter of 2023. 3rd quarter: Day shift: 7/4/23, 12:00 pm. Evening shift: 7/20/23, 7:15 pm, 8/22/23, 9:52 pm. Night shift: 9/30/23, 11:00 pm. 4th quarter: Day shift: 10/31/23, 8:30 am. The review did not indicate any evacuation drills were run during the evening and night shifts in the fourth quarter of 2023. Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "Evacuation drills should be done every month on a different shift. Each shift would have a drill each quarter. New hires are supposed to do them as well. For the purpose of evacuation drills, our shifts are 7:00 am to 3:00 pm, 3:00 pm to 11:00 pm, and 11:00 pm to 7:00 am." Chief Operations Officer (COO) #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "Evacuation drills should be done once per shift per quarter." 9-3-7(a)			
W 0448 Bldg. 00	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. Based on record review 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 address clients #1, #2, #3, #4, #5, #6, and #7	W 0448	Staff were retrained on fire drills on 3-8-24 and 3-28-24. A plan was developed to reduce the time it takes to evacuate. Staff were trained on the plan. The DCCQA	03/31/2024

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	evacuation times during drills. Findings include: Clients #1, #2, #3, #4, #5, #6, and #7's evacuation drills were reviewed on 2/27/24 at 11:37 am and indicated the following evacuation times: 2/16/23 at 12:37 pm, 5 minutes. 3/28/23 at 10:00 pm, 10 minutes. 4/24/23 at 8:40 pm, 20 minutes. 5/13/23 at 6:00 pm, 10 minutes. 6/8/23 at 7:10 am, 20 minutes. 7/4/23 at 12:00 pm, 8 minutes. 7/20/23 at 7:15 pm, 5 minutes. 9/30/23 at 11:00 pm, 20 minutes. 10/31/23 at 8:30 am, 10 minutes. 1/19/24 at 2:35 pm, 15 minutes. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "I don't know what the policy is for time on a fire drill. It should not take 20 minutes to evacuate for a fire. There should be an investigation or follow-up for how long it is taking." Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "They should be able to evacuate within a few minutes. It should be much less than that. We should have a follow-up and retraining." 9-3-7(a)		will review these drills each month and track the trends and continue to look for areas of reducing evacuation times. This approach is applied to all 4 homes.	
W 0474 Bldg. 00	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. Based on observation, record review, and interview for 1 of 3 sample clients (#2), the facility	W 0474	All staff were retrained on dining risk plans on 3-8-24 and	03/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G636	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	failed to ensure client #2's meal was served according to her dining plan. Findings include: An observation was conducted in the group home on 2/26/24 from 3:15 pm to 5:30 pm. Client #2 was present in the home throughout the observation period. On 2/26/24 at 5:07 pm, client #2 was served chopped pork and whole peas with mashed potatoes and unaltered canned fruit. Client #2's record was reviewed on 2/28/24 at 11:24 am. Client #2's dining plan dated July 2023 indicated the following: "Mechanical soft ground beef texture." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "[Client #2's] food should look almost smooth. She has ground beef texture. It should be kind of smooth and soft and pliable. Chopped meat and whole fruit is not ok." Director of Corporate Compliance and Quality Assurance #1 was interviewed on 2/29/24 at 10:30 am and stated, "The dining plan should be followed." 9-3-8(a)		again on 3-27-24. This included texture of the food, needed dining equipment and sitting at the table during mealtime. Compliance will be checked during observation by the manager or management team. Corrective action will result if not done correctly.	
W 0484 Bldg. 00	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.			

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	15G636	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Based on observation, record review, and interview for 1 of 3 sample clients (#1), the facility failed to ensure client #1 had access to her adaptive dining equipment. Findings include: An observation was conducted in the group home on 2/26/24 from 3:15 pm to 5:30 pm. Client #1 was present in the home throughout the observation period. On 2/26/24, client #1 was served her evening meal at 5:07 pm. Direct Support Professional (DSP) #1 was provided a spoon with a built up handle and a metal bowl and a plate with shallow lip and notch in one side. While eating her pureed meal, client #1 independently used the spoon to scoop food towards her body. Some of the food remained on the spoon and some pushed off of the plate and onto her shirt. When client #1 bit down on the spoon, food fell onto her face and shirt protector from both sides of her mouth. Client #1's record was reviewed on 2/28/24 at 12:23 pm. Client #1's dining plan dated July 2023 indicated the following adaptive equipment: "Scoop plate. Built-up, coated spoon." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "[Client #1] should have a coated spoon and a scoop plate." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "[Client #1] should	W 0484	All staff were retrained on dining risk plans on 3-8-24 and again on 3-27-24. This included texture of the food, needed dining equipment and sitting at the table during mealtime. Compliance will be checked during observation by the manager or management team. Corrective action will result if not done correctly. All needed dining items are present in all homes.	03/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G636	A. BUILDING 00 B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	use a coated spoon. Whatever the plan says, they should have. She should have the scoop plate. She's had that forever." Chief Operations Officer (COO) #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "The spoon and plate should be available." 9-3-8(a)			
W 9999 Bldg. 00	State Findings 460 IAC 9-3-2(c)(3) Resident protections Authority: IC 12-28-5-19 Affected: IC 4-21.5;IC 5-2-55; IC 12-28-5-12; IC 22-12 (c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: The provider shall obtain, as a minimum (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section. This State rule is not met as evidenced by: Based on observation, record review, and interview for 1 staff file reviewed, the facility to ensure staff #3 had 3 references confirmed prior to employment. Findings include: The facility's employee files were reviewed on 2/27/24 at 11:20 am.	W 9999	The Human Resources Director will ensure staff obtain three references before employment is offered. This applies to all homes. Without three references, no jobs will be offered. The person without three references was corrected.	03/31/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

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	Staff #3's record indicated a start date of 2/8/24 and did not include any references. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/28/24 at 2:11 pm and stated, "Staff should have 3 references before being hired. We need to call and confirm them." Director of Corporate Compliance and Quality Assurance #1 was interviewed by phone on 2/29/24 at 10:30 am and stated, "Staff should have 3 references. Our HR (Human Resources) department reaches out to those references. They have a sheet they fill out and ask a few questions." Chief Operations Officer (COO) #1 was interviewed by phone on 3/1/24 at 9:46 am and stated, "There should be three references. They can verify them with phone or email, just so long as we're checking those." Recruiter #1 was interviewed on 2/27/24 at 1:27 pm and stated, "[Staff #3] gave us bogus phone numbers. He should have had 3 references before he starts working." 9-3-2(c)(3)			