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	04/23/2024

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 the Post Certification Revisit to the predetermined full recertification and state licensure survey completed on 3/7/24. Dates of Survey: April 16, 17, 18, 19, 22, and 23, 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 #27547 on 5/1/24.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 allegation of neglect reviewed for client #3, the facility failed to implement its written policy and procedure to immediately report and thoroughly investigate one injury of unknown origin for client #3. Findings include: The facility's Bureau of Disability Services (BDS) reports and related investigations were reviewed on 4/16/24 at 2:33 pm. A BDS report dated 4/4/24 indicated the following: "On 4/3/24 at around 8:30 am, [client #3] was taken	W 0149	Staff are trained to report any possible injuries immediately. All staff are trained to document all possible injuries after communicating those injuries. Staff who fail to report immediately and who fail to document will receive corrective action. This was not reported on the first day of discovery as the nurse said there was no injury. When an actual injury was found on 4-3-24, it was reported immediately (within 4 hours) of discovery. Going forward, even if the nurse	05/16/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dan Peterson	DCCQA	05/16/2024

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	to the ER (emergency room) for seizure activity. While at the ER, [client #3] had swelling in his right hand. X-rays revealed his right hand was broken. A soft splint was applied. [Client #3] has an appointment with [orthopedic surgeon]. An investigation was started as to the cause of the injury." An investigation dated 4/5/24 indicated the following: - "On 4/1/24 [Day Program Staff (DPS) #1] reported [client #3's] hand looked swollen. [DPS #1] stated on 4/4/24 at 9:00 am, that she asked the nurse to look at [client #3's] hand, and the nurse did. [DPS #1] stated that [client #3's] hand was swollen over his knuckles and on 4/2/24, his hand looked more swollen. [DPS #1] stated [client #3] grimaced in pain when trying to transfer him and his hand was touched." - "On 4/4/24 [Registered Nurse (RN) #1] stated she looked at [client #3's] hand on 4/4/24 and that there was no bruising and no problems with range of motion when she manipulated his hand. [RN #1] stated his arm was bruised from recent hospitalization from IV (intravenous) and lab draws." - "On 4/4/24 at 10:45 am, [Direct Support Professional (DSP) #2] was interviewed.... [DSP #2] stated she noticed [client #3's] hand was swollen on 4/2/24 but did not notice the swelling on 4/1/24." - "[Client #3] was hospitalized on 3/28/24 through 3/29/24. [Client #3] was also hospitalized on 3/25/24 through 3/26/24. Staff did not complete body checks thoroughly each time he returned home."		examines an individual and reports there are no injuries as this was the case in this incident, Corvilla, will still report the possible injury immediately and report at this time no injury was found. Staff were trained in completing body assessments when returning from the hospital or home visits. This did not occur in this situation. Staff will receive corrective action , going forward, if this occurs again. Managers are required and trained to turn in body assessments as they occur to the QIDP. The QIDP will track these assessments for compliance. If corrective action occurs, the QIDP will let the DCCQA know for tracking purposes of corrective action. If indicated, staff will do daily assessments on individuals if required to do so. This did not happen in this case. If this is needed again, the QIDP, will check the records daily to ensure staff are completing the daily assessments. If not completed, the staff will receive corrective action. If corrective action occurs, the QIDP will let the DCCQA know for tracking purposes of corrective action. Going forward, late reporting will be included in all investigations, including the staff's name and corrective action applied for the late reporting.	

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	"Recommendations: - Retrain staff on completing the body assessments when [client #3] leaves and returns from the hospital. - Staff should do daily body assessments on [client #3] due to his risk of falling, scooting on the floor, and trying to walk without staff assistance." A staff note written by DPS #1 and dated 4/1/24 was reviewed on 4/18/24 at 12:30 pm and indicated the following: "Change of Condition: Upon changing [client #3] staff noticed when transferring him, his right hand was swollen, no redness or discoloration, just puffy. He did show a little bit of agitation. When checking him over, he had bruises on his arm where he had previous IVs. The nurse was notified, and she said to keep (sic) eye on it (sic) report any changes." The review indicated the note was reviewed by Director of Corporate Compliance and Quality Assurance (DCCQA) #1 on 4/1/24 at 3:20 pm. The review indicated the note was reviewed by Registered Nurse (RN) #1 on 4/2/24 at 9:00 am. RN #1 was interviewed on 4/16/24 at 2:37 pm and stated, "[Client #3's] hand looked swollen. There was no bruising or wincing. He went to the hospital for a seizure. They ended up x-raying his hand. I have no idea how, when, or where it happened." RN #1 stated, "I was not here on 4/1/24. I looked at it on 4/4/24 (sic). It was not swollen over his knuckles. If it were me, I would have said something to someone. I teach a class. When they find an injury, something not normal, they should immediately report to a supervisor. I'm not aware if there is a written policy."			

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	DCCQA #1 was interviewed by phone on 4/22/24 at 11:08 am and stated, "Staff reported the swollen hand on 4/1/24. The nurse looked at it that day (sic) and didn't think anything was wrong with it. On 4/4/24, the hospital found his hand was broken." DCCQA #1 stated, "The nurse should have done a nursing note when she assessed the hand. They have a nursing notes section they can put things on. She did not document it." DCCQA #1 stated, "It was an injury of unknown origin. It was reported on 4/3/24. That's when I found out about it. The nurse looked at it on 4/2/24. The staff did the GER (General Event Report) on 4/1/24 when they saw it, but they didn't report to anyone. I didn't find out until 4/3/24. The staff should have reported on 4/1/24. The late reporting should be addressed in the investigation." - The review indicated DPS #1 did not immediately notify a supervisor of client #3's swollen hand when she noticed it. - RN #1 indicated she looked at client #3's hand on 4/4/24. DCCQA and facility records indicated RN #1 examined client #3's hand on 4/2/24. - The review did not include any nursing notes regarding RN #1 looking at client #3's hand. - DCCQA indicated he was not aware of the injury of unknown origin until 4/3/24. The facility records indicate DCCQA reviewed and approved DPS #1's staff note regarding the injury of unknown origin on 4/1/24. - The facility did not report the injury of unknown origin to BDS within 24 hours of knowledge. - The facility did not address late reporting in the investigation of the incident. The facility's undated Incident Reporting and Management Policy was reviewed on 4/22/24 at 1:30 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 referred 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...." This deficiency was cited on 3/7/24. The facility			

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	failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 injury of unknown origin for client #3, the facility failed to ensure staff working with client #3 immediately reported an injury of unknown origin to a supervisor. Findings include: The facility's Bureau of Disability Services (BDS) reports and related investigations were reviewed on 4/16/24 at 2:33 pm. A BDS report dated 4/4/24 indicated the following: "On 4/3/24 at around 8:30 am, [client #3] was taken to the ER (emergency room) for seizure activity. While at the ER, [client #3] had swelling in his right hand. X-rays revealed his right hand was broken. A soft splint was applied. [Client #3] has an appointment with [orthopedic surgeon]. An investigation started as to the cause of the injury." An investigation dated 4/5/24 indicated the following: - "On 4/1/24 [Day Program Staff (DPS) #1] reported [client #3's] hand looked swollen. [DPS #1] stated on 4/4/24 at 9:00 am, that she asked the	W 0153	Staff are trained to report any possible injuries immediately. All staff are trained to document all possible injuries after communicating those injuries. Staff who fail to report immediately and who fail to document will receive corrective action. This was not reported on the first day of discovery as the nurse said there was no injury. When an actual injury was found on 4-3-24, it was reported immediately (within 4 hours) of discovery. Going forward, even if the nurse examines an individual and reports there are no injuries as this was the case in this incident, Corvilla, will still report the possible injury immediately and report at this time no injury was found. Staff were trained in completing body assessments when returning from the hospital or home visits. This did not occur in this situation. Staff will receive	05/16/2024

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	nurse to look at [client #3's] hand, and the nurse did. [DPS #1] stated that [client #3's] hand was swollen over his knuckles and on 4/2/24, his hand looked more swollen. [DPS #1] stated [client #3] grimaced in pain when trying to transfer him and his hand was touched." - "On 4/4/24 [Registered Nurse (RN) #1] stated she looked at [client #3's] hand on 4/4/24 and that there was no bruising and no problems with range of motion when she manipulated his hand. [RN #1] stated his arm was bruised from recent hospitalization from IV (intravenous) and lab draws." - "On 4/4/24 at 10:45 am, [Direct Support Professional (DSP) #2] was interviewed.... [DSP #2] stated she noticed [client #3's] hand was swollen on 4/2/24 but did not notice the swelling on 4/1/24." - "[Client #3] was hospitalized on 3/28/24 through 3/29/24. [Client #3] was also hospitalized on 3/25/24 through 3/26/24. Staff did not complete body checks thoroughly each time he returned home." "Recommendations: - Retrain staff on completing the body assessments when [client #3] leaves and returns from the hospital. - Staff should do daily body assessments on [client #3] due to his risk of falling, scooting on the floor, and trying to walk without staff assistance." A staff note written by DPS #1 and dated 4/1/24 was reviewed on 4/18/24 at 12:30 pm and indicated the following: "Change of Condition:		corrective action , going forward, if this occurs again. Managers are required and trained to turn in body assessments as they occur to the QIDP. The QIDP will track these assessments for compliance. If corrective action occurs, the QIDP will let the DCCQA know for tracking purposes of corrective action. If indicated, staff will do daily assessments on individuals if required to do so. This did not happen in this case. If this is needed again, the QIDP, will check the records daily to ensure staff are completing the daily assessments. If not completed, the staff will receive corrective action. If corrective action occurs, the QIDP will let the DCCQA know for tracking purposes of corrective action. Going forward, late reporting will be included in all investigations, including the staff's name and corrective action applied for the late reporting.	

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	Upon changing [client #3] staff noticed when transferring him, his right hand was swollen, no redness or discoloration, just puffy. He did show a little bit of agitation. When checking him over, he had bruises on his arm where he had previous IVs. The nurse was notified, and she said to keep (sic) eye on it (sic) report any changes." The review indicated the note was reviewed by Director of Corporate Compliance and Quality Assurance (DCCQA) #1 on 4/1/24 at 3:20 pm. The review indicated the note was reviewed by Registered Nurse (RN) #1 on 4/2/24 at 9:00 am. RN #1 was interviewed on 4/16/24 at 2:37 pm and stated, "[Client #3's] hand looked swollen. There was no bruising or wincing. He went to the hospital for a seizure. They ended up x-raying his hand. I have no idea how, when, or where it happened." RN #1 stated, "I was not here on 4/1/24. I looked at it on 4/4/24 (sic). It was not swollen over his knuckles. If it were me, I would have said something to someone. I teach a class. When they find an injury, something not normal, they should immediately report to a supervisor. I'm not aware if there is a written policy." DCCQA #1 was interviewed by phone on 4/22/24 at 11:08 am and stated, "Staff reported the swollen hand on 4/1/24. The nurse looked at it that day (sic) and didn't think anything was wrong with it. On 4/4/24, the hospital found his hand was broken." DCCQA #1 stated, "The nurse should have done a nursing note when she assessed the hand. They have a nursing notes section they can put things on. She did not document it." DCCQA #1 stated, "It was an injury of unknown origin. It was reported on 4/3/24. That's when I found out about it. The nurse looked at it on 4/2/24. The staff did the GER (General Event			

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	Report) on 4/1/24 when they saw it, but they didn't report to anyone. I didn't find out until 4/3/24. The staff should have reported on 4/1/24. The late reporting should be addressed in the investigation." - The review indicated DPS #1 did not immediately notify a supervisor of client #3's swollen hand when she noticed it. - DCCQA indicated he was not aware of the injury of unknown origin until 4/3/24. The facility records indicate DCCQA reviewed and approved DPS #1's staff note regarding the injury of unknown origin on 4/1/24. - The facility did not report the injury of unknown origin to BDS within 24 hours of knowledge. This deficiency was cited on 3/7/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for injury of unknown origin for client #3, the facility failed to thoroughly investigate an injury of unknown origin for client #3. Findings include: The facility's Bureau of Disability Services (BDS) reports and related investigations were reviewed on 4/16/24 at 2:33 pm. A BDS report dated 4/4/24 indicated the following: "On 4/3/24 at around 8:30 am, [client #3] was taken	W 0154	Staff are trained to report any possible injuries immediately. All staff are trained to document all possible injuries after communicating those injuries. Staff who fail to report immediately and who fail to document will receive corrective action. This was not reported on the first day of discovery as the nurse said there was no injury. When an actual injury was found on 4-3-24, it was reported	05/16/2024

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	to the ER (emergency room) for seizure activity. While at the ER, [client #3] had swelling in his right hand. X-rays revealed his right hand was broken. A soft splint was applied. [Client #3] has an appointment with [orthopedic surgeon]. An investigation started as to the cause of the injury." An investigation dated 4/5/24 indicated the following: - "On 4/1/24 [Day Program Staff (DPS) #1] reported [client #3's] hand looked swollen. [DPS #1] stated on 4/4/24 at 9:00 am, that she asked the nurse to look at [client #3's] hand, and the nurse did. [DPS #1] stated that [client #3's] hand was swollen over his knuckles and on 4/2/24, his hand looked more swollen. [DPS #1] stated [client #3] grimaced in pain when trying to transfer him and his hand was touched." - "On 4/4/24 [Registered Nurse (RN) #1] stated she looked at [client #3's] hand on 4/4/24 and that there was no bruising and no problems with range of motion when she manipulated his hand. [RN #1] stated his arm was bruised from recent hospitalization from IV (intravenous) and lab draws." - "On 4/4/24 at 10:45 am, [Direct Support Professional (DSP) #2] was interviewed.... [DSP #2] stated she noticed [client #3's] hand was swollen on 4/2/24 but did not notice the swelling on 4/1/24." - "[Client #3] was hospitalized on 3/28/24 through 3/29/24. [Client #3] was also hospitalized on 3/25/24 through 3/26/24. Staff did not complete body checks thoroughly each time he returned home."		immediately (within 4 hours) of discovery. Going forward, even if the nurse examines an individual and reports there are no injuries as this was the case in this incident, Corvilla, will still report the possible injury immediately and report at this time no injury was found. Staff were trained in completing body assessments when returning from the hospital or home visits. This did not occur in this situation. Staff will receive corrective action , going forward, if this occurs again. Managers are required and trained to turn in body assessments as they occur to the QIDP. The QIDP will track these assessments for compliance. If corrective action occurs, the QIDP will let the DCCQA know for tracking purposes of corrective action. If indicated, staff will do daily assessments on individuals if required to do so. This did not happen in this case. If this is needed again, the QIDP, will check the records daily to ensure staff are completing the daily assessments. If not completed, the staff will receive corrective action. If corrective action occurs, the QIDP will let the DCCQA know for tracking purposes of corrective action. Going forward, late reporting will be included in all investigations, including the staff's	

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	"Recommendations: - Retrain staff on completing the body assessments when [client #3] leaves and returns from the hospital. - Staff should do daily body assessments on [client #3] due to his risk of falling, scooting on the floor, and trying to walk without staff assistance." A staff note written by DPS #1 and dated 4/1/24 was reviewed on 4/18/24 at 12:30 pm and indicated the following: "Change of Condition: Upon changing [client #3] staff noticed when transferring him, his right hand was swollen, no redness or discoloration, just puffy. He did show a little bit of agitation. When checking his over, he had bruises on his arm where he had previous IVs. The nurse was notified, and she said to keep (sic) eye on it (sic) report any changes." - The review indicated the note was reviewed by Director of Corporate Compliance and Quality Assurance (DCCQA) #1 on 4/1/24 at 3:20 pm. - The review indicated the note was reviewed by Registered Nurse (RN) #1 on 4/2/24 at 9:00 am. RN #1 was interviewed on 4/16/24 at 2:37 pm and stated, "[Client #3's] hand looked swollen. There was no bruising or wincing. He went to the hospital for a seizure. They ended up x-raying his hand. I have no idea how, when, or where it happened." RN #1 stated, "I was not here on 4/1/24. I looked at it on 4/4/24 (sic). It was not swollen over his knuckles. If it were me, I would have said something to someone. I teach a class. When they find an injury, something not normal, they should immediately report to a supervisor. I'm not aware if there is a written policy."		name and corrective action applied for the late reporting.	

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	DCCQA #1 was interviewed by phone on 4/22/24 at 11:08 am and stated, "Staff reported the swollen hand on 4/1/24. The nurse looked at it that day (sic) and didn't think anything was wrong with it. On 4/4/24, the hospital found his hand was broken." DCCQA #1 stated, "The nurse should have done a nursing note when she assessed the hand. They have a nursing notes section they can put things on. She did not document it." DCCQA #1 stated, "It was an injury of unknown origin. It was reported on 4/3/24. That's when I found out about it. The nurse looked at it on 4/2/24. The staff did the GER (General Event Report) on 4/1/24 when they saw it, but they didn't report to anyone. I didn't find out until 4/3/24. The staff should have reported on 4/1/24. The late reporting should be addressed in the investigation." - The review indicated DPS #1 did not immediately notify a supervisor of client #3's swollen hand when she noticed it. - RN #1 indicated she looked at client #3's hand on 4/4/24. DCCQA and facility records indicated RN #1 examined client #3's hand on 4/2/24. - The review did not include any nursing notes regarding RN #1 looking at client #3's hand. - DCCQA indicated he was not aware of the injury of unknown origin until 4/3/24. The facility records indicate DCCQA reviewed and approved DPS #1's staff note regarding the injury of unknown origin on 4/1/24. - The facility did not address late reporting in the investigation of the incident. This deficiency was cited on 3/7/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			

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	15G636	A. BUILDING 00 B. WING	04/23/2024

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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 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 client #3's need for a guardian was assessed within 30 days of his admission to the group home, develop an Individual Support Plan (ISP) for client #3 within 30 days of admission to the group home, and ensure clients #1 and #2 had ISPs. Findings include: 1. The QIDP failed to ensure client #3's need for a guardian was assessed within 30 days of his admission to the group home. Please see W210. 2. The QIDP failed to develop an ISP for client #3 within 30 days of admission to the group home. Please see W226. 3. The QIDP failed to ensure clients #1 and #2 had ISPs. Please see W260. Director of Corporate Compliance and Quality Control (DCCQA) #1 was interviewed on 4/22/24 at 11:08 am and stated, "The QIDP does the CFAs and ISPs." This deficiency was cited on 3/7/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	W 0159	Going forward, all Comprehensive Functional Assessments will address guardianship whether there is a need for a guardian, if the person has a guardian, or a statement that no guardian is needed. All CFA's will be reviewed by the Residential Director for compliance and tracked by the Residential Director to ensure completion. The QIDP was not working at Corvilla during the time of the missing ISP's so they could not falsify these documents. The QIDP has since established a new ISP date by having a meeting and these are completed. The Residential Director will track all ISP's and their due dates to ensure compliance. There are no missing ISP's at any home. All new admissions are completed within 30 days and the Residential Director will track these for compliance.	05/16/2024

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W 0192 Bldg. 00	9-3-3(a) 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 client #1's dining harness. Findings include: An observation was conducted in the group home on 4/16/24 from 3:33 pm to 6:00 pm. Client #1 was present in the home throughout the observation period. On 4/16/24 at 5:14 pm, Direct Support Professional (DSP) #2 instructed client #1 to stand up from her chair at the table. DSP #2 placed the shoulder straps for client #1's dining harness over her shoulders, and the bottom strap between client #1's legs. DSP #2 instructed client #1 to sit down on her dining chair. DSP #2 secured the dining harness to the chair using the attached buckles. The dining harness was loose and did not hold client #1 up. At 5:21 pm, client #1 was served pureed steak, vegetables, and bread. Client #1 leaned over her plate while she ate, and her face was close to her plate. DSPs #1, #2, and #5 and House Manager (HM) #1 were in the dining room watching the meal and did not adjust client #1's dining harness. At 5:30 pm, HM #1 assisted client #1 with hand-over-hand. At 5:33 pm, the surveyor asked	W 0192	Staff were retrained on using the dining harness correctly on 3-8-24 and again on 3-28-24 and 4-25-24. 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.	05/16/2024

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	HM #1 about client #1's dining harness. HM #1 stated, 'It shouldn't be loose. It is not on correctly. She should be sitting on it. It should go under the chair, so it will hold her up." Client #1's record was reviewed on 4/16/24 at 12:47 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 4/18/24 at 12:37 pm and stated, "Staff were trained to use the dining harness. She needs room to move, but it should be form fitting." Director of Corporate Compliance and Quality Control (DCCQA) #1 was interviewed by phone on 4/22/24 at 11:08 am and stated, "Staff have been trained to use the dining harness. It should be tight enough to hold her up." This deficiency was cited on 3/7/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)			
W 0210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 1 of 3	W 0210	Going forward, all	05/16/2024

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	sample clients (#3), the facility failed to ensure client #3's need for a guardian was assessed within 30 days of his admission to the group home. Findings include: Client #3's record was reviewed on 4/16/24 at 12:33 pm and indicated an admission date of 10/7/23. Client #3's CFA dated 3/28/24 did not indicate an assessment of his guardianship needs. 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. An observation was conducted in client #3's hospital room on 4/17/24 from 10:34 am to 10:59 am. Client #3 was lying in his hospital bed wearing an adult brief and covered by a bedsheet. Client #3 turned toward a speaker when spoken to but did not respond to questions or otherwise interact with his caretaker. Hospital Registered Nurse (RN) #1 was completing skin checks for client #3. Hospital RN #1 indicated client #3 had been hospitalized due to uncontrolled seizures since 4/8/24. Hospital RN #1 stated, "He was transferred to this floor yesterday. His seizures have been controlled since 4/16/24 at 9:30 am. We're going to start his g-tube back up (feeding tube). We couldn't do a feed due to a risk of aspiration. We're looking for another placement. He requires another level of care." Hospital Social Worker #1 was interviewed on 4/17/24 at 10:59 am and stated, "[Client #3] has a sitter now. When we try to remove the sitter, he tries to get out of bed. It's not safe. He needs hands-on care for safety. It's not for medical		Comprehensive Functional Assessments will address guardianship whether there is a need for a guardian, if the person has a guardian, or a statement that no guardian is needed. All CFA's will be reviewed by the Residential Director for compliance and tracked by the Residential Director to ensure completion. All persons served will have a guardianship assessment completed at least annually by the QIDP. The Residential Director will track for compliance. All individuals who do not have an assessment will have one completed.	

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	needs. BDS (Bureau of Disability Services) says he has to sign consent to be moved. He can't sign himself. They won't allow the parents to give consent because they aren't the guardian." BDS Staff #1 was interviewed by phone on 4/18/24 at 9:45 am and stated, "[Client #3] does not have a guardian. He is emancipated. The family isn't involved or willing to find a placement for him. He is not able to make his own decisions or to give consent." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 4/18/24 at 12:37 pm and stated, "Guardianship was not addressed in the CFA." QIDP #1 indicated progress was being made towards finding a guardian for client #3. Director of Corporate Compliance and Quality Assurance (DCCQA) #1 was interviewed by phone on 4/22/24 at 11:08 am and stated, "Guardianship should be addressed in the assessment within 30 days of admission." This deficiency was cited on 3/7/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 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.	W 0226	The QIDP was not working at Corvilla during the time of the missing ISP's so they could not falsify these documents. The QIDP has since established a new	05/16/2024

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	Findings include: Client #3's record was reviewed on 4/16/24 at 12:33 pm and indicated an admission date of 10/7/23. Client #3's record did not include an ISP. House Manager (HM) #1 was interviewed on 4/16/24 at 5:55 pm and indicated staff in the home did not have access to ISP for client #3. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 4/18/24 at 12:37 pm and stated, "We couldn't find [client #3's] ISP. It's not time for his annual meeting, and we can't go back to recreate what was talked about before." QIDP #1 stated, "We could have a new meeting to create a new ISP." Director of Corporate Compliance and Quality Assurance (DCCQA) #1 was interviewed by phone on 4/22/24 at 11:08 am and stated, "[QIDP #1] wasn't here for [client #3's] ISP. We couldn't go back to recreate it. I did reach out to BDS (Bureau of Disability Services) to see if they had a copy, but they didn't. If we needed to, we could have done a new meeting." DCCQA #1 indicated staff working in the home should have access to current plans. This deficiency was cited on 3/7/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)		ISP date by having a meeting and these are completed. The Residential Director will track all ISP's and their due dates to ensure compliance. There are no missing ISP's at any home. All new admissions are completed within 30 days and the Residential Director will track these for compliance.	
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			

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	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's Individual Support Plans (ISPs) were revised annually. Findings include: 1. Client #1's record was reviewed on 4/16/24 at 12:47 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 4/16/24 at 1:01 pm and indicated an admission date of 1/3/2014. Client #2's record did not include an ISP. House Manager (HM) #1 was interviewed on 4/16/24 at 5:55 pm and indicated staff in the home did not have access to ISPs for clients #1 and #2. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 4/18/24 at 12:37 pm and stated, "We couldn't find [clients #1 and #2's] ISPs. It's not time for their annual meetings, and we can't go back to recreate what was talked about before." QIDP #1 stated, "We could have a new meeting to create new ISPs." Director of Corporate Compliance and Quality Assurance (DCCQA) #1 was interviewed by phone on 4/22/24 at 11:08 am and stated, "[QIDP #1] wasn't here for those ISPs. We couldn't go back to recreate them. I did reach out to BDS (Bureau of Disability Services) to see if they had a copy, but they didn't. If we needed to, we could have done a new meeting." DCCQA #1 indicated staff working in the home should have access to current plans.	W 0260	The QIDP was not working at Corvilla during the time of the missing ISP's so they could not falsify these documents. The QIDP has since established a new ISP date by having a meeting and these are completed. The Residential Director will track all ISP's and their due dates to ensure compliance. There are no missing ISP's at any home. All new admissions are completed within 30 days and the Residential Director will track these for compliance.	05/16/2024

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	This deficiency was cited on 3/7/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(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, 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's medications were stored in a secure manner. Findings include: An observation was conducted in the group home on 4/16/24 from 3:33 pm to 6:00 pm. Clients #1, #2, #4, #5, #6, and #7 were present in the home throughout the observation period. Client #3 was hospitalized at the time of the survey, but his medications were stored in the group home medication room throughout the observation period. On 4/16/25 at 3:33 pm, the medication room door was open. The room was not occupied. Clients #1, #2, #3, #4, #5, #6, and #7's medications were stored in baskets on open shelves and were not secured inside the room. Controlled medications were stored inside a locked box. At 3:46 pm, the medication room door was closed and locked. At 3:50 pm, the medication room door was open, and the room was unoccupied. House	W 0382	All staff were retrained in Medication Administration on 3-8-2024 and 3-28-24 and 4-25-24. 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.	05/16/2024

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	Manager (HM) #1 walked into the room to get a cup and went back into the kitchen. HM #1 did not close the door. At 3:57 pm, Direct Support Professional (DSP) #1 entered the home and went into the medication room through the open door. At 3:58 pm, DSP #1 left the medication room and left the door open. At 4:00 pm, HM #1 went into the medication room then left. The door remained open. At 4:04 pm, the door to the medication room was closed and remained closed when not in use through the end of the observation period at 6:00 pm. DSP #2 was interviewed on 4/16/24 at 5:40 pm and stated, "The medication room door should be shut." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 4/18/24 at 12:37 pm and stated, "Medications should be stored behind a locked door at all times." The Director of Corporate Compliance and Quality Assurance was interviewed by phone on 4/22/24 at 11:08 am and stated, "The medication room door should be closed and locked." This deficiency was cited on 3/7/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			
W 0454 Bldg. 00	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and interview for 2 of 3 sample clients (#1 and #2), plus 3 additional	W 0454	All staff were retrained on hand washing on 3-8-24 and again on	05/16/2024

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	clients (#5, #6, and #7), the facility failed to ensure staff working in the home implemented universal precautions in regards to handwashing for clients #1, #2, #5, #6, and #7 and to ensure clients #2 and #5's food was kept separate after they had begun eating. Findings include: Observations were conducted in the group home on 4/16/24 from 3:33 pm to 6:00 pm. Clients #1, #2, #5, #6, and #7 were present in the home throughout the observation period. 1. On 4/16/24 at 3:40 pm, Direct Support Professional (DSP) #2 was in the kitchen preparing the evening meal, and House Manager (HM) #1 was in client #4's bedroom with the door closed. Client #2 was in her bedroom. At 3:40 pm, client #2 walked from her bedroom to the bathroom with her pants and underwear around her knees. Client #2 sat down on the toilet from 3:40 pm to 3:43 pm. The bathroom door was open. At 3:43 pm, client #2 got up from the toilet, pulled up her pants, and went back to her bedroom. Client #2 did not flush the toilet, wipe herself, or wash her hands. There was urine in the toilet. Staff working in the home did not see client #2 use the toilet and did not prompt her to wipe herself or to wash her hands. 2. On 4/16/24 at 5:21 pm, clients #1, #2, #5, #6, and #7 were served their evening meal at the dining table and did not wash or sanitize their hands. Clients #1, #2, #5, #6, and #7 were not prompted to wash or sanitize their hands before eating. 3. On 4/16/24 at 5:21 pm, clients #2 and #5 were served dinner rolls cut into 2 inch pieces, and steak cut into one inch pieces. Staff placed the		3-27-24 and 4-25-24. House manager will observe and enforce hand washing for clients when appropriate. Management team will observe for this during random observations. Staff not washing hands or prompting clients to wash hands will receive corrective action. A toileting privacy goal will be added for a client that does not shut the bathroom door. Management team will monitor for client privacy during random observations. Staff was retrained on dining plans on 4-25-24. Staff will prepare foods separately for each person to ensure no cross contamination. The house manager will monitor on his shift. Management team will monitor food preparation during random observations.	

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	plates in front of clients #2 and #5 and prompted them to begin eating. The surveyor asked HM #1 to identify the consistency of the steak and bread. HM #1 stated, "It's not mechanical soft. It's too big. It needs to be put in the blender." HM #1 instructed the staff to moisten the bread and to blend the steak. DSP #1 took the steak from both plates, put it in the blender, added broth, and ground the meat into a mechanical soft texture. Broth was added to clients #2 and #5's bread. Clients #2 and #5's plates were given back to them. Clients #2 and #5's meals were not ground separately after they had begun eating from their plates. DSP #2 was interviewed on 4/16/24 at 5:40 pm and stated, "Clients should wash their hands before eating. They all need to be prompted." DSP #2 stated, "[Client #2] should have assistance every time she goes to the bathroom. She needs prompts for wiping and hand washing." HM #1 was interviewed on 4/16/24 at 5:55 pm and stated, "Everyone should wash their hands before and after eating. They needs prompts and assistance from staff." HM #1 stated, "[Client #2] needs help with washing her hands. Sometimes she goes (to the bathroom) without anyone noticing. We have to prompt her to wipe and to wash her hands." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 4/16/24 at 12:37 pm and stated, "[Client #2] has a goal for handwashing. She does need assistance." QIDP #1 stated, "Staff should prompt for everyone to wash their hands before eating. They all need assistance." QIDP #1 stated, "The meals should have been ground one at a time, and the blender should have been cleaned between each person			

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	04/23/2024

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

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	with soap and water." 9-3-7(a)			
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), plus 1 additional client (#5), the facility failed to ensure clients #2 and #5's meals were served according to their dining plans. Findings include: An observation was conducted in the group home on 4/16/24 from 3:33 pm to 6:00 pm. Clients #2 and #5 were present in the home throughout the observation period. On 4/16/24 at 5:21 pm, clients #2 and #5 were served dinner rolls cut into 2 inch pieces, and steak cut into one inch pieces. Staff placed the plates in front of clients #2 and #5 and prompted them to begin eating. The surveyor asked House Manager #1 to identify the consistency of the steak and bread. HM #1 stated, "It's not mechanical soft. It's too big. It needs to be put in the blender." HM #1 instructed the staff to moisten the bread and to blend the steak. DSP #1 took the steak from both plates, put it in the blender, added broth, and ground the meat into a mechanical soft texture. Broth was added to clients #2 and #5's bread. Clients #2 and #5's plates were given back to them. 1. Client #2's record was reviewed on 4/16/24 at 1:01 pm. Client #2's dining plan dated July 2023 indicated	W 0474	All staff were retrained on dining risk plans on 3-8-24 and again on 3-27-24 and 4-25-24. This included texture of the food, needed dining equipment and sitting at the table during mealtime. This includes not blending individuals foods together. Compliance will be checked during observation by the manager or management team. Corrective action will result if not done correctly.	05/16/2024

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	the following: "Mechanical soft, ground beef texture." 2. Client #5's record was reviewed on 4/16/24 at 1:22 pm. Client #5's dining plan dated July 2023 indicated the following: "Mechanical soft, ground beef texture." Direct Support Professional (DSP) #2 was interviewed on 4/16/24 at 5:40 pm and stated, "I was trained on the dining plan. The trainer came in and showed us. She showed me how to do chicken, but there is a lot of stuff we haven't done before. This was my first time doing steak. I didn't know how to do it." DSP #2 indicated the Qualified Intellectual Disabilities Professional (QIDP) had observed a meal in the group home. HM #1 was interviewed on 4/16/24 at 5:55 pm and stated, "I have trained the staff on the dining plans. [DSP #2] gets nervous. I trained them, and the dietician has observed. [The QIDP assistant] has been in to observe a meal." QIDP #1 was interviewed on 4/18/24 at 12:37 pm and indicated she did not remember clients #2 and #5's dining plans. QIDP #1 looked at a photo of the meat served to clients #2 and #5 on the surveyor's phone and stated, "That is not mechanical soft." This deficiency was cited on 3/7/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-8(a)			