

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

PRINTED: 10/26/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G636		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/01/2021	
NAME OF PROVIDER OR SUPPLIER CORVILLA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3202 S FELLOWS SOUTH BEND, IN 46614			
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00362280.</p> <p>Complaint #IN00362280: Substantiated, federal/state deficiencies related to the allegation are cited at W192, W249 and W331.</p> <p>Survey Dates: 9/29/21, 9/30/21 and 10/1/21.</p> <p>Facility Number: 001212 Provider Number: 15G636 AIM Number: 100240190</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #39778 on 10/12/21.</p>		W 0000				
W 0192 Bldg. 00	<p>483.430(e)(2) STAFF TRAINING PROGRAM</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (A), the facility failed to ensure staff were adequately trained to complete aspiration tracking following a choking incident.</p> <p>Findings include:</p> <p>On 9/29/21 at 2:10 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 9/8/21 at 6:00 PM, "On 9/8/21 while helping another client at the table [client A] began</p>		W 0192	<p>All Corvilla staff that work directly with individuals that reside in the group homes will be retrained on all risk plans, which includes the dining risk plans. Changes to the dining risk plans will be made if necessary. The QIDP and nurse will follow up with all group homes and day programs to ensure that retraining was completed. This will be shown via documentation from all staff that provide direct care with those individuals.</p>		10/20/2021	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>coughing. ([Client A] is on a puree diet with thin liquids. He has a history of eating at a fast rate with large bites. Staff are to cue him to take smaller bites or to slow down when this behavior is noted.) Staff did attempt to cue him to slow down while eating but [client A] continued to eat at a fast rate. Staff then noted that the coughing became worse and [client A] appeared to be in distress. Staff started to encourage [client A] to continue coughing but noted that was not working and started to give [client A] 5 back blows. [Client A] continued to cough and staff then started the Heimlich Maneuver (a maneuver which works by creating an artificial cough by pushing up on the diaphragm and forces air out of the lungs and up through the throat, forcing a trapped object out). Once started [client A] was able to cough up his food and the coughing had stopped. [Client A] took a drink of his milk and left the table. Staff continued to monitor him through out the night. Aspiration sheets were started and will be in place x (times) 2 weeks. [Client A] did not appear to be in distress from the incident and appeared to be doing ok and vital were WNL (within normal limits). [Client A] is scheduled to be seen by a doctor on Friday morning due to agency protocol for choking.</p> <p>Plan to Resolve: SGL (Supervised Group Living) staff will continue to follow [client A's] diet risk plan to help prevent choking incidents in the future. All staff will be retrained on his choking plan per our policy. SGL staff will continue to complete aspiration sheets x 2 weeks. If any s/s (signs and symptoms) of aspiration are noted staff will call agency nurse for further instructions. [Client A] will follow up with a doctor Friday 9/10/21."</p> <p>On 9/30/21 at 9:30 AM, a review of client A's</p>				<p>All staff will also be retrained on the aspiration tracking sheet, which is discussed during CORE A/B of new staff orientation. This includes all have staff and day program staff. Nurse will ensure that all aspiration sheets will be turned in each day for two weeks. The aspiration sheets will be completed on each shift (7am-3 pm, 3pm-10pm, 10pm-8am). House and day program manager will work together to ensure that these sheets have been completed by their staff. If it is not completed on a shift, staff will notify the nurse and disciplinary action will ensue for the staff on shift. Disciplinary action will be completed by house or day program manager. Aspiration checks include completing temperature, pulse, respirations, and blood pressure checks. Staff will also note if there has been a change in mood. If an individual that recently has choked refuses these checks, staff will notify house nurse and try again later in the shift. Temperature, respirations, and changes in daily mood can be documented even if blood pressure is refused by individual. Staff will be reminded that these are still able to be checked by group home manager and house nurse. If there are any changes occur during the check, such in a rise or fall of blood pressure or</p>		

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	<p>Potential Aspiration Management sheets completed for 2 weeks indicated the following:</p> <p>- "Potential Aspiration Management: Essential Monitoring after Potential Aspiration Incident Worksheet Purpose: A possible aspiration event could include but is not limited to: - Vomiting episode when sleeping or if person is unable to move themselves into sidelying (laying on side) or forward to prevent inhaling vomitus (vomit). - Choking episode (airway was blocked). - Coughing with struggle (red face, watery eyes, runny nose/coughing with eating). - Runny nose occurring during eating. - Excessive drooling. - Aspiration does not always present itself immediately following a choking incident even on x-rays. The food or fluid that gets aspirated may get into lungs and over a few days may cause an infection. If an infection develops signs and symptoms will appear in a few days. 1. Staff must call Nurse to report any and all potential aspiration incidents. 2. This form should be completed every shift for 2 weeks. 3. Form to be sent or scanned to Corvilla nurse daily for 2 weeks."</p> <p>The following Potential Aspiration Management sheets for client A from 9/9/21 to 9/22/21 were reviewed and indicated the following:</p> <p>- 9/9/21 2:30 PM - 10:30 PM: temperature, respiration, pulse, and blood pressure sections indicated the client refused. Changes in general mood section marked yes. - 9/9/21 10:00 PM - 8:00 AM: temperature,</p>				<p>temperature, etc., the house nurse will be notified immediately. An individual that has choked will be seen within 24 hours after choking incident. All choking incidents will be investigated by the director of corporate compliance. Changes will be made to the dining risk plan if necessary.</p>		

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	<p>respiration, pulse, and blood pressure sections indicated the client refused. Changes in general mood section marked yes.</p> <p>-9/10/21 8:00 AM - 2:30 PM: no documentation present.</p> <p>-9/10/21 2:30 PM - 10:30 PM: no documentation present. Changes in general mood section marked yes.</p> <p>-9/10/21 10:00 PM - 8:00 AM: temperature, respiration, pulse, and blood pressure sections indicated the client refused. Changes in general mood section marked yes.</p> <p>-9/11/21 8:00 AM - 4:00 PM: respiration section blank. Changes in general mood section marked yes.</p> <p>-9/11/21 2:30 - 10:30 PM: pulse and blood pressure sections blank and indicated the client refused.</p> <p>-9/11/21 10:00 PM - 8:00 AM: no documentation present.</p> <p>-9/12/21 8:00 AM - 2:30 PM: no documentation present.</p> <p>-9/12/21 2:30 PM - 10:30 PM: no documentation present.</p> <p>-9/12/21 10:00 PM - 8:00 AM: temperature, respiration, pulse and blood pressure sections indicated the client refused. Changes in general mood section marked yes.</p> <p>-9/13/21 8:00 AM - 2:30 PM: no documentation present.</p> <p>-9/13/21 2:30 PM - 10:30 PM: no documentation present.</p> <p>-9/13/21 10:30 PM - 8:00 AM: no documentation present.</p> <p>-9/14/21 8:00 AM - 2:30 PM: no documentation present.</p> <p>-9/14/21 2:30 PM - 10:30 PM: no documentation present.</p> <p>-9/14/21 10:00 PM - 8:00 AM: respiration, pulse and blood pressure sections indicated the</p>						

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	<p>client refused. Changes in general mood section marked yes. Cough section marked yes, kinda (kind of) a common cough.</p> <p>-9/15/21 8:00 AM - 2:30 PM: no documentation present.</p> <p>-9/15/21 2:30 - 10:30 PM: respiration section marked NA (not applicable) and the pulse section indicated the client refused.</p> <p>-9/15/21 10:00 PM - 8:00 AM: respiration section blank. Changes in general mood section marked yes.</p> <p>-9/16/21 8:00 AM - 2:30 PM: no documentation present.</p> <p>-9/16/21 2:30 PM - 10:30 PM: no documentation present.</p> <p>-9/16/21 10:00 PM - 8:00 AM: respiration, pulse and blood pressure sections indicated the client refused. Changes in general mood section marked yes.</p> <p>-9/17/21 8:00 AM - 2:30 PM: no documentation present.</p> <p>-9/17/21 2:30 - 10:30 PM: respiration and pulse sections indicated the client refused. Blood pressure 139/88 notified nurse of agitation while taking vitals.</p> <p>-9/17/21 10:00 PM - 8:00 AM: respiration section left blank. Pulse 64, nurse notified, continue to monitor, retake and call if pulse does not increase.</p> <p>-9/18/21 8:00 AM - 4:00 PM: respiration section left blank.</p> <p>-9/18/21 4:00 PM - 10:00 PM: no documentation present.</p> <p>-9/18/21 10:00 PM - 8:00 AM: temperature, respiration, pulse and blood pressure sections indicated the client refused. Changes in decreased food intake, decreased fluid intake, refusal of meals, refusal of fluid intake, difficulty in breathing, changes in general mood, cough, lethargy, chest congestion, pale gray-blue</p>						

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	<p>skin in extremities, lips or fingernails and change in sleeping habits all left blank.</p> <p>-9/19/21 8:00 AM - 2:30 PM: no documentation present.</p> <p>-9/19/21 2:30 - 10:30 PM: temperature, respiration, pulse and blood pressure sections indicated the client refused.</p> <p>-9/19/21 10:00 PM - 8:00 AM: temperature, respiration, pulse and blood pressure sections indicated the client refused. Changes in decreased food intake, decreased fluid intake, refusal of meals, refusal of fluid intake, difficulty in breathing, changes in general mood, cough, lethargy, chest congestion, pale gray-blue skin in extremities, lips or fingernails and change in sleeping habits all left blank.</p> <p>-9/20/21 8:00 AM - 2:30 PM: no documentation present.</p> <p>-9/20/21 2:30 - 10:30 PM: temperature, respiration, pulse and blood pressure sections indicated the client refused.</p> <p>-9/20/21 10:30 PM - 8:00 AM: no documentation present.</p> <p>-9/21/21 8:00 AM - 2:30 PM: no documentation present.</p> <p>-9/21/21 Note indicating 2nd shift did not do [client A's] aspiration sheet.</p> <p>-9/21/21 10:00 PM - 8:00 AM: respiration, pulse and blood pressure sections indicated the client refused.</p> <p>-9/22/21 8:00 AM - 2:30 PM: no documentation present.</p> <p>-9/22/21 2:30 - 10:30 PM: temperature, respiration and pulse sections indicated the client refused.</p> <p>-9/22/21 10:00 PM - 8:00 AM: respiration, pulse and blood pressure sections indicated the client refused. General changes section marked yes.</p>						

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W 0249 Bldg. 00	<p>On 9/29/21 at 5:54 PM, the TL (Team Lead) stated, "[Client A] does not like to be bothered especially when he is eating or having to get his vitals taken." The TL stated, "[Client A] really enjoys eating and will get agitated if he does not get to eat when and how he likes to. [Client A] tends to eat at a fast rate and take large bites, we remind him to slow down and take smaller bites but he gets upset when we do."</p> <p>On 9/30/21 at 11:26 AM, the nurse indicated the day program staff were told by me (the nurse) and communicated to the home staff to begin the aspiration tracking. The nurse indicated the home manager asked when the tracking should have been completed. The nurse indicated the home manager identified the tracking had not been done at day program. The nurse stated, "The home manager was to inform the rest of the home staff when the tracking was to be completed. The aspiration tracking is listed within the HRP (High Risk Plan)." The nurse stated, "Sometimes the staff just will not do it (take vitals) because they (the staff) do not understand how to. I have provided them (the staff) the training in Core A and B and have supplied them with a folder with detailed descriptions of how to complete the vitals." The nurse stated, "The documentation I provided was what was provided to me."</p> <p>This federal tag relates to complaint #IN00362280.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan,</p>						

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	<p>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.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (A), the facility failed to ensure staff implemented the aspiration tracking following a choking incident.</p> <p>Findings include:</p> <p>On 9/29/21 at 2:10 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 9/8/21 at 6:00 PM, "On 9/8/21 while helping another client at the table [client A] began coughing. ([Client A] is on a puree diet with thin liquids. He has a history of eating at a fast rate with large bites. Staff are to cue him to take smaller bites or to slow down when this behavior is noted.) Staff did attempt to cue him to slow down while eating but [client A] continued to eat at a fast rate. Staff then noted that the coughing became worse and [client A] appeared to be in distress. Staff started to encourage [client A] to continue coughing but noted that was not working and started to give [client A] 5 back blows. [Client A] continued to cough and staff then started the Heimlich Maneuver (a maneuver which works by creating an artificial cough by pushing up on the diaphragm and forces air out of the lungs and up through the throat, forcing a trapped object out). Once started [client A] was able to cough up his food and the coughing had stopped. [Client A] took a drink of his milk and left the table. Staff continued to monitor him through out the night. Aspiration sheets were</p>	W 0249	<p>All Corvilla staff that work directly with individuals that reside in the group homes will be retrained on all risk plans, which includes the dining risk plans. Changes to the dining risk plans will be made if necessary. The QIDP and nurse will follow up with all group homes and day programs to ensure that retraining was completed. This will be shown via documentation from all staff that provide direct care with those individuals.</p> <p>All staff will also be retrained on the aspiration tracking sheet, which is discussed during CORE A/B of new staff orientation. This includes all have staff and day program staff. Nurse will ensure that all aspiration sheets will be turned in each day for two weeks. The aspiration sheets will be completed on each shift (7am-3 pm, 3pm-10pm, 10pm-8am). House and day program manager will work together to ensure that these sheets have been completed by their staff. If it is not completed on a shift, staff will notify the nurse and disciplinary action will ensue for the staff on shift. Disciplinary action will be completed by house or day program manager.</p>		10/20/2021		

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	<p>started and will be in place x (times) 2 weeks. [Client A] did not appear to be in distress from the incident and appeared to be doing ok and vital were WNL (within normal limits). [Client A] is scheduled to be seen by a doctor on Friday morning due to agency protocol for choking.</p> <p>Plan to Resolve: SGL (Supervised Group Living) staff will continue to follow [client A's] diet risk plan to help prevent choking incidents in the future. All staff will be retrained on his choking plan per our policy. SGL staff will continue to complete aspiration sheets x 2 weeks. If any s/s (signs and symptoms) of aspiration are noted staff will call agency nurse for further instructions. [Client A] will follow up with a doctor Friday 9/10/21."</p> <p>On 9/30/21 at 9:30 AM, a review of client A's Potential Aspiration Management sheets completed for 2 weeks indicated the following:</p> <p>- "Potential Aspiration Management: Essential Monitoring after Potential Aspiration Incident Worksheet Purpose: A possible aspiration event could include but is not limited to: -Vomiting episode when sleeping or if person is unable to move themselves into sidelying (laying on side) or forward to prevent inhaling vomitus (vomit). -Choking episode (airway was blocked). -Coughing with struggle (red face, watery eyes, runny nose/coughing with eating). -Runny nose occurring during eating. -Excessive drooling. -Aspiration does not always present itself immediately following a choking incident even on x-rays. The food or fluid that gets aspirated may get into lungs and over a few days may cause</p>				<p>Aspiration checks include completing temperature, pulse, respirations, and blood pressure checks. Staff will also note if there has been a change in mood. If an individual that recently has choked refuses these checks, staff will notify house nurse and try again later in the shift. Temperature, respirations, and changes in daily mood can be documented even if blood pressure is refused by individual. Staff will be reminded that these are still able to be checked by group home manager and house nurse.</p> <p>If there are any changes occur during the check, such in a rise or fall of blood pressure or temperature, etc., the house nurse will be notified immediately. An individual that has choked will be seen within 24 hours after choking incident.</p> <p>All choking incidents will be investigated by the director of corporate compliance. Changes will be made to the dining risk plan if necessary.</p>		

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	<p>an infection. If an infection develops signs and symptoms will appear in a few days.</p> <ol style="list-style-type: none"> 1. Staff must call Nurse to report any and all potential aspiration incidents. 2. This form should be completed every shift for 2 weeks. 3. Form to be sent or scanned to Corvilla nurse daily for 2 weeks." <p>-During the day shift (8:00 AM to 2:30 PM), the facility failed to complete the Potential Aspiration Management sheets on:</p> <p>-9/9/21 -9/10/21 -9/11/21 -9/13/21 -9/14/21 -9/15/21 -9/16/21 -9/17/21 -9/18/21 -9/20/21 -9/21/21 -9/22/21</p> <p>-During the evening shift (2:30 PM to 10:30 PM), the facility failed to complete the Potential Aspiration Management sheets on:</p> <p>-9/8/21 -9/9/21 -9/11/21 -9/13/21 -9/14/21 -9/15/21 -9/16/21 -9/17/21 -9/19/21 -9/20/21 -9/21/21 -9/22/21</p>						

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	<p>-During the overnight shift (10:30 PM to 8:00 AM), the facility failed to complete the Potential Aspiration Management sheets on:</p> <p>-9/8/21 -9/9/21 -9/10/21 -9/11/21 -9/12/21 -9/13/21 -9/14/21 -9/15/21 -9/16/21 -9/17/21 -9/18/21 -9/19/21 -9/20/21 -9/21/21 -9/22/21</p> <p>A review of client A's 6/2021 Risk Management Plan/Dining indicated the following:</p> <p>- "Risk Involved:</p> <p>a. Choking</p> <p>b. Aspiration: Aspiration does not always present itself immediately following a choking incident, even on x-rays. The food or fluid that gets aspirated may get into the lungs, and over a few days may cause an infection. If an infection develops, signs and symptoms will appear in a few days.</p> <p>Signs and symptoms may include the following:</p> <p>-Decreased food and/or fluid intake. -Refusal of meals or fluids. -Temperature elevation (check twice per day; be sure you know what is not OK for the individual). -Changes in respiratory rate, pulse or blood pressure (twice per day; be sure you know what is not OK for the individual).</p>						

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

PRINTED: 10/26/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G636		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/01/2021	
NAME OF PROVIDER OR SUPPLIER CORVILLA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3202 S FELLOWS SOUTH BEND, IN 46614			
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	<p>-Skin color change (pale/gray/blue), especially in extremities, lips or fingernails.</p> <p>-Cough</p> <p>-Chest congestion</p> <p>-Change in sleeping habits - more or less than before the potential incident.</p> <p>-Diet Order - Pureed diet"</p> <p>On 9/29/21 at 5:54 PM, the TL (Team Lead) stated, "[Client A] does not like to be bothered especially when he is eating or having to get his vitals taken." The TL stated, "[Client A] really enjoys eating and will get agitated if he does not get to eat when and how he likes to. [Client A] tends to eat at a fast rate and take large bites, we remind him to slow down and take smaller bites but he gets upset when we do."</p> <p>On 9/30/21 at 11:26 AM, the nurse indicated the day program staff were told by me (nurse) and it was communicated to the home staff. The home manager asked when the tracking should have been completed. The home manager identified the tracking had not been done at day program. The nurse stated, "The home manager was to inform the rest of the home staff when the tracking was to be completed. The aspiration tracking is listed within the HRP (High Risk Plan)." The nurse stated, "Sometimes the staff just will not do it (take vitals) because they (the staff) do not understand how to. I have provided them (the staff) the training in Core A and B and have supplied them with a folder with detailed descriptions of how to complete the vitals." The nurse stated, "The documentation I provided was what was provided to me." The nurse indicated the tracking should have been completed. The nurse stated, "[Client A] is typically non-compliant and will flail (wave or swing) his</p>						

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W 0331 Bldg. 00	<p>arms when staff are trying to complete the vitals."</p> <p>This federal tag relates to complaint #IN00362280.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 clients in the sample (A), the facility's nursing services failed to ensure staff were adequately trained to complete and implement the aspiration tracking following a choking incident.</p> <p>Findings include:</p> <p>1) Please refer to W192. For 1 of 3 clients in the sample (A), the facility failed to ensure staff were adequately trained to complete aspiration tracking following a choking incident.</p> <p>2) Please refer to W249. For 1 of 3 clients in the sample (A), the facility failed to ensure staff implemented the aspiration tracking following a choking incident.</p> <p>On 9/30/21 at 11:26 AM, the nurse indicated the managers were responsible for ensuring their staff are completing them (the aspiration tracking) and turning them into the nurse weekly for nurse review. When asked if the aspiration tracking was turned in daily, the nurse stated, "The group home manager only turns them in weekly, she is picky about who turns the documentation in and when." The nurse indicated she did not follow up on the documentation.</p>		W 0331	<p>All staff will also be retrained on the aspiration tracking sheet, which is discussed during CORE A/B of new staff orientation. This will be completed by company nurse. This includes all have staff and day program staff. Nurse will ensure that all aspiration sheets will be turned in each day for two weeks. The QIDP and Director of Corporate compliance will confirm each day that all aspiration sheets have been completed. The aspiration sheets will be completed on each shift (7am-3 pm, 3pm-10pm, 10pm-8am). House and day program manager will work together to ensure that these sheets have been completed by their staff. If it is not completed on a shift, staff will notify the nurse and disciplinary action will ensue for the staff on shift. Disciplinary action will be completed by house or day program manager. Aspiration checks include completing temperature, pulse,</p>		10/19/2021	

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	<p>This federal tag relates to complaint #IN00362280.</p> <p>9-3-6(a)</p>			<p>respirations, and blood pressure checks. Staff will also note if there has been a change in mood. If an individual that recently has choked refuses these checks, staff will notify house nurse and try again later in the shift. Temperature, respirations, and changes in daily mood can be documented even if blood pressure is refused by individual. Staff will be reminded that these are still able to be checked by group home manager and house nurse.</p> <p>If there are any changes occur during the check, such in a rise or fall of blood pressure or temperature, etc., the house nurse will be notified immediately. An individual that has choked will be seen within 24 hours after choking incident.</p> <p>All choking incidents will be investigated by the director of corporate compliance. Changes will be made to the dining risk plan if necessary.</p>			