

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G377	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2015
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NAME OF PROVIDER OR SUPPLIER CORVILLA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 52549 MYRTLE ST SOUTH BEND, IN 46637
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0000 Bldg. 01	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 09/24/15</p> <p>Facility Number: 000891 Provider Number: 15G377 AIM Number: 100244320</p> <p>At this Life Safety Code survey, Corvilla, Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility with a basement was not sprinklered. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in client sleeping rooms and in common living areas. The facility has a capacity of 7 and had a census of 7 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</p>	K 0000		

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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K 0130 Bldg. 01	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.8.</p> <p>Quality Review on 09/28/15 - DA</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Kitchen fire extinguishers requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p> <p>Based on observation and interview on 09/24/15 at 1:36 p.m., the Qualified Intellectual Disability Professional acknowledged the maintenance tag on fire extinguisher in the Kitchen indicated the last six year test was completed 07/2009. The annual fire extinguisher inspection was last performed on 08/15/15.</p>	K 0130	To ensure compliance with this standard the fire extinguisher in the kitchen was replaced on September 30, 2015. To ensure a deficiency of this nature does not occur inthe future, the Maintenance Personnel will be responsible for monitoring the maintenance tag on all fire extinguishers in Corvilla's home twice yearly as well as each home's Manager.	09/30/2015			
K S018	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD						

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Bldg. 01	<p>Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4</p> <p>Doors are self-closing or automatic closing in accordance with 7.2.1.8</p> <p>Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2. Based on observation and interview, the facility failed to ensure 1 of 4 sleeping room doors would close and latch into the door frame. This deficient practice could affect 2 of 7 clients in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Qualified Intellectual Disability Professional at 1:30 p.m. on 09/24/15, South Bedroom door did not latch into the door frame when tested. Based on interview at the time of observation, the Qualified Intellectual Disability Professional acknowledged the aforementioned condition.</p>	K S018	The door latch and the door hinge were repaired and adjusted on September 30, 2015. To ensure a deficiency of this nature does not occur in the future the Maintenance Personnel will be responsible for monitoring and maintaining the doors in the homes monthly.	09/30/2015			