STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G377	A. BUILDING -- B. WING	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	52549 MYRTLE ST SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 03/11/2025 Facility Number: 000891 Provider Number: 15G377 AIM Number: 100244320 At this Emergency Preparedness survey, Corvilla, Inc. was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 7 certified beds. All 7 beds are certified for Medicaid. At the time of the survey, the census was 7. Quality Review completed on 03/12/25	E 0000		
E 0015 Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.1 Subsistence Needs for Staff and Patients Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies (ii) Alternate sources of energy to maintain (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions	E 0015	E015-**Subsistence Needs for Staff and Patients:** Regarding the citation E015, the maintenance supervisor has posted a list of 4 vendors to provide support for Sewerage and waste disposal in each group home. The Maintenance supervisor will review, monitor and update at least every 2 years, please see attached documentation. The maintenance	04/03/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michele A Lofton	Director of Residential Services	04/03/2025

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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	(B) Emergency lighting (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all clients and staff. Findings include: Based on record review and interview with the Residential Director, Qualified Intellectual Disabilities Professional (QIDP), Maintenance Technician and QIDP Technician on 03/11/2025 between 11:58 a.m. and 2:27 p.m., the provided plan did not address (D) sewage and waste disposal. Based on interview after the Residential Director, Maintenance Technician and QIDP Technician looked through the Emergency Preparedness Plan and other facility policy binders the Residential Director acknowledged no documentation of a policy regarding sewage and waste was available for review. This finding was reviewed with the Maintenance Technician and QIDP Technician during the exit conference.		supervisor has added the yearly maintenance tracking form and schedule.	
E 0018 Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(Procedures for Tracking of Staff and Patients Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location	E 0018	E018- **Procedures for Tracking Staff and Patients:** Regarding E018, The QIDP will place a tracking system in each group home's emergency relocation bins as well as the group homes emergency binders in the event of emergency relocation. They will include each	04/03/2025

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	in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all clients and staff. Findings include: Based on record review and interview with the Residential Director, Qualified Intellectual Disabilities Professional (QIDP), Maintenance Technician and QIDP Technician on 03/11/2025 between 11:58 a.m. and 2:27 p.m., the facility failed to provide documentation regarding a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency, if on-duty staff and sheltered clients are relocated during the emergency. Based on interview at the time of record review, the Maintenance Technician stated he was unable to locate a policy for tracking staff and clients. This finding was reviewed with the Maintenance Technician and QIDP Technician during the exit conference.		staff member on duty and sheltered patients in the facilities care during an emergency. It will contain the location of the receiving facility (guardians' home, hotel etc.). In the event of an actual emergency location, the QIDP will ensure and maintain the completed tracking sheet is kept on file. /p> /p> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" b=""> ="" span=""> ="" b=""> ="" span=""> ="" b=""> ="" span=""> ="" span=""> ="" b=""> ="" b=""> ="" span=""> ="" span=""> ="" b=""> ="" span=""	
E 0032 Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(Primary/Alternate Means for Communication Based on record review and interview, the facility failed to ensure the Emergency Preparedness Communication Plan includes (3) Primary and	E 0032	E032- **Primary and Alternate means of Communication-**	04/03/2025

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	alternate means for communicating with the following: (i) ICF/IID facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.475(c)(3). This deficient practice could affect all clients and staff. Findings include: Based on record review and interview with the Residential Director, Qualified Intellectual Disabilities Professional (QIDP), Maintenance Technician and QIDP Technician on 03/11/2025 between 11:58 a.m. and 2:27 p.m., the facility failed to provide an Emergency Preparedness Communication Plan that addressed primary and alternate means for communicating with the following: (i) ICF/IID facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies. Based on interview at the time of record review the Maintenance Technician stated the Communication Plan addressed telephone as a means of communication but not an alternate means of communication. This finding was reviewed with the Maintenance Technician and QIDP Technician during the exit conference.		Regarding E032, Corvilla Inc. has placed an Emergency Preparedness Plan that outlines Communication Sources for Tier 2 and Tier 3 Natural Disasters as well as a Communication Plan that keeps all stakeholders informed in the event of an emergency in binders in each group home. The QIDP or Residential Director will update the Emergency Preparedness Plan as feasible.	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/11/2025 Facility Number: 000891	K 0000		

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	15G377	A. BUILDING 01 B. WING	03/11/2025

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	Provider Number: 15G377 AIM Number: 100244320 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 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. 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, 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. The facility has heat detection in the attic. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.96. Quality Review completed on 03/12/25			
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 1.) Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals	K S345	K S0345- **Fire Alarm System- Testing and Maintenance.** Regarding K S0345, the maintenance supervisor will inspect, monitor and document all facility smoke detectors are within their listed and marked sensitivity range every 6 months according to the maintenance schedule. The maintenance supervisor will work	04/03/2025

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	b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all clients and staff. Findings include: Based on record review and interview with the Residential Director, Qualified Intellectual Disabilities Professional (QIDP), Maintenance Technician and QIDP Technician on 03/11/2025 between 11:58 a.m. and 2:27 p.m., documentation dated 11/14/2024 was provided indicating an annual fire alarm system test and inspection had been completed but no documentation could be provided regarding a visual semi-annual fire alarm system inspection during the 6 months prior to 11/24/2024. Based on interview at the time of record review, the Maintenance Technician stated there was no documentation for a semi-annual visual fire alarm system inspection available for review. 2.) Based on record review and interview, the facility failed to ensure all facility smoke detectors were within their listed and marked sensitivity range. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. Section 9.6.1.3 states a fire alarm system shall be installed, tested and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and 14.4.5.3.2 states every alternate year thereafter. After the second required		with the alarm company to document the new style/sensitives smoke detector sensitivity to be used with our current system. The maintenance supervisor will keep documentation for review.	

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	calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on record review and interview with the Residential Director, Qualified Intellectual Disabilities Professional (QIDP), Maintenance Technician and QIDP Technician on 03/11/2025 between 10:25 a.m. and 12:09 p.m., documentation			

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	dated 11/14/2024 was provided indicating an annual fire alarm system test and inspection had been completed; however, no indication or documentation of a sensitivity test was provided. Based on interview at the time of record review, the Maintenance Technician acknowledged the documentation of smoke detector sensitivity testing was not available. These findings were reviewed with the Maintenance Technician and QIDP Technician during the exit conference.			
K S500 Bldg. 01	NFPA 101 Building Services - Other Based on observation, record review, and interview, the facility failed to maintain a complete written record of monthly generator testing for 12 of 12 months. LSC 4.5.7 states any building service equipment or safeguard provided to achieve the goals of this Code shall be designed, installed, and approved in accordance with applicable NFPA codes. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 8.4.1 states an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. Section 8.4.2.4 states spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. NFPA 110, Section 8.3.4 states a permanent record of EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. NFPA 110, Section 8.3.7.1 states maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be	K S500	K S0500- **Building Services-Other** **The maintenance supervisor will maintain a complete written record of monthly load testing of the generator or battery testing located. The maintenance supervisor will document and keep current documentation available for review. Please see the uploaded documentation.**	03/31/2025

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	15G377	A. BUILDING 01 B. WING	03/11/2025

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	permitted in lieu of the testing of specific gravity when applicable or warranted. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review and interview with the Residential Director, Qualified Intellectual Disabilities Professional (QIDP), Maintenance Technician and QIDP Technician on 03/11/2025 between 11:58 a.m. and 2:27 p.m., documentation of monthly generator testing was not available for review. A checklist of items inspected by facility and/or maintenance staff was provided but failed to include information on monthly load testing of the generator or battery testing. Based on observation, the facility has a Generac 22kW natural gas fired emergency generator located outside of the facility on the side of the facility. Based on observation with the Maintenance Technician during a tour of the facility on 03/11/2025 between 2:28 p.m. and 2:55 p.m., one natural gas fired emergency generator was located outside the facility in the back yard. This finding was reviewed with the Maintenance Technician and QIDP Technician during the exit conference.			
K S741 Bldg. 01	NFPA 101 Smoking Regulations Based on record review and interview, the facility failed to provide a smoking policy. LSC 33.7.4.1 states smoking regulations shall be adopted by the administration of board and care occupancies. This deficient practice affects all clients, staff and visitors. Findings include:	K S741	K S0741: **Smoking Regulations:** Regarding K S0741, Corviila's Smoking Policy will be posted in each Group home. The QIDP or Q-Tech will ensure staff are aware and adhere to the Smoking policy.	04/03/2025

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	Based on record review and interview with the Residential Director, Qualified Intellectual Disabilities Professional (QIDP), Maintenance Technician and QIDP Technician on 03/11/2025 between 11:58 a.m. and 2:27 p.m., documentation of a facility smoking policy was not available for review. Based on interview, the Residential Director stated she knew the corporate office has a smoking policy but was not able to locate any documentation at the facility. During tour of the facility no evidence of smoking or a designated smoking area was found. This finding was reviewed with the Maintenance Technician and QIDP Technician during the exit conference.			