

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 01/05/24</p> <p>Facility Number: 000891 Provider Number: 15G377 AIM Number: 100244320</p> <p>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</p> <p>The facility has 7 certified beds. All 7 beds are certified for Medicaid. At the time of the survey, the census was 6.</p> <p>Quality Review completed on 01/08/24</p>	E 0000		
E 0039 Bldg. --	<p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)</p> <p>EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at</p>			

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

TITLE

(X6) DATE

Dan Peterson

DCCQA

01/17/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>\$491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or</p> <p>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or</p> <p>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>--</u> B. WING <u> </u>	(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p> *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual,</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <ul style="list-style-type: none"> (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <ul style="list-style-type: none"> (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise 			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u> </u> B. WING <u> </u>	(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>the [RNHCl's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCl must conduct exercises to test the emergency plan. The RNHCl must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCl's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCl's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to analyze the facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events. The ICF/IID facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p>	E 0039	<p>The DCCQA will collect sign-in sheets for community exercises. If the community exercise will not provide a sign-in sheet for verification, the DCCQA will use Corvilla's sign in sheet for those Corvilla staff in attendance. The DCCQA has created a tracking sheet to track all exercises and drills to ensure the yearly obligation is met. One tabletop exercise will be scheduled annually as well. All actual events are tracked if they occur.</p>	01/17/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>--</u> B. WING <u> </u>	(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>b. A mock disaster drill; or</p> <p>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Program (EPP) with the Maintenance Director on 01/05/24 between 10:37 a.m. and 11:22 a.m., the documentation for the emergency preparedness workshop conducted on 07/13/23 was incomplete. There was no sign in sheet to verify which staff were present for community disaster responses and Hazard Vulnerability Assessment (HVA), the only documentation present for that exercise was a summary of what was done in the workshop. Furthermore, no documentation of a community-based exercise or facility-based exercise was available for review. Based on interview at the time of record review, the Maintenance Director stated that the person who is responsible for the drills was out of town and unable to present additional documentation of the exercise reviewed at the time of the survey.</p> <p>Findings were discussed with the Maintenance Director at exit conference.</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G377	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
K 0000 Bldg. 01	<p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 01/05/24</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 2012 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 one client sleeping room and in common living areas. The facility has a capacity of 7 and had a census of 6 at the time of this survey. The facility has heat detection in the attic.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, could not be determined at this time because no F-1's were provided. LSC Chapter 32.2.1.2.2 states where such documentation is not furnished, the evacuation capability shall be classified as Impractical.</p> <p>Quality Review completed on 01/08/24</p>	K 0000		

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

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 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
KS100 Bldg. 01	<p>NFPA 101</p> <p>General Requirements - Other</p> <p>General Requirements - Other</p> <p>2012 EXISTING</p> <p>List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on records review and interview, the facility failed to provide 6 of 6 F-1 work sheets to the authority having jurisdiction to be able to determine an evacuation assistance score in accordance with LSC 33.2.1.2.2 which states that facility management shall furnish to the authority having jurisdiction, upon request, an evacuation capability determination using a procedure acceptable to the authority having jurisdiction; where such documentation is not furnished, the evacuation capability shall be classified as impractical. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director on 01/05/24 between 11:51 p.m. and 2:30 p.m., the facility was unable to provide F1 worksheets used to rate the resident and determine the resident's overall need for assistance when requested. Based on interview at the time of record review, the Maintenance Director stated he has not seen the F1 worksheets in the home and was unable to find them during the survey.</p> <p>Findings were discussed with the Maintenance Director at exit conference.</p>	K S100	<p>The F1 sheets for this location were completed. The DCCQA will track the F1's annually and ensure they are completed. If they are not completed the DCCQA will contact the Residential Director or QIDP who will ensure their completion and will enforce corrective action on those responsible for not completing the F1's on time. All other locations were checked and have current F1's.</p>	01/17/2024

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

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 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
K S359 Bldg. 01	<p>NFPA 101</p> <p>Sprinkler System - Installation</p> <p>Sprinkler System - Installation</p> <p>2012 EXISTING (Impractical)</p> <p>All Impractical Evacuation Capability facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 33.2.3.5.3.</p> <p>The system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with 9.6, as modified below. The adequacy of the water supply shall be documented.</p> <p>In Impractical Evacuation Capability Facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in one-and-two-Family Dwellings and Manufactured Homes, with a 30 minute water supply, shall be permitted. All habitable areas and closets shall be sprinklered.</p> <p>Automatic Sprinklers shall not be required in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials provided a 15-minute thermal barrier.</p> <p>In Impractical Evacuation Capability Facilities up to and including four stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, shall be permitted.</p> <p>All habitable areas and closets shall be sprinklered. Automatic sprinklers shall not be required in bathrooms not exceeding 55 square feet provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier.</p> <p>Initiation of the fire alarm system shall not be</p>			

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 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>required for existing installations in accordance with 33.2.3.5.6.</p> <p>Attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected, by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following:</p> <ol style="list-style-type: none"> 1. Protected by heat detection system to activate the fire alarm system according to 9.6 by July 5, 2019. 2. Protected by automatic sprinkler system according to 9.7, by July 5, 2019. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. <p>33.2.3.5.3, 33.2.3.5.3.2, 33.2.3.5.3.5 through 33.2.3.5.3.7, 42 CFR 483.470(j)(1)(ii)</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems were supervised for Impractical Evacuation Capability. LSC 33.2.3.5.3.7 states all impractical evacuation capability facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 33.2.3.5.3. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based record review with the Maintenance Director on 01/05/24 between 10:37 a.m. and 11:22 a.m., the calculation of the evacuation score from F1 forms was impractical based on F1 forms missing from the survey. This would make the facility rating be an Impractical Evacuation Capability. Based on interview at the time of record review, the facility was unsprinklered and stated he was unaware of the regulation and confirmed F1 forms were unable to be found during the survey.</p>	K S359	<p>The F1 sheets for this location were completed. The DCCQA will track the F1's annually and ensure they are completed. If they are not completed the DCCQA will contact the Residential Director or QIDP who will ensure their completion and will enforce corrective action on those responsible for not completing the F1's on time. All other locations were checked and have current F1's.</p> <p>The DCCQA tracks all fire drills. When not completed by the 15th of each month, the Residential Director/QIDP will be notified to rectify the situation. If the situation is not corrected by the end of the month, the manager of the home will receive corrective action. The Residential</p>	01/17/2024

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 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
K S511 Bldg. 01	<p>Findings were discussed with the Maintenance Director at exit conference.</p> <p>NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code.</p> <p>32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect approximately 2 clients and staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/05/24 between 11:26 a.m. and 12:00 p.m., the Southwest bedroom, at the end of the hall, contained a power strip behind a dresser that was dangling, unsecured, from the power cord used to power electronic appliances. This condition could put stress on the power cord</p>	K S511	<p>Director/QIDP will complete the drill before the end of the month to ensure compliance if needed.</p> <p>The house does not have a sprinkler system based on the F1's and needs of the folks living there.</p> <p>The power cord was replaced the day of the inspection. All other sites were checked for this deficiency and corrected. Going forward, this will be part of maintenances' monthly inspection to ensure they are not being used and as part of Corvilla's quarterly safety inspections.</p>	01/10/2024

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 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
K S712 Bldg. 01	<p>causing damage to the power cord. Based on interview at the time of observation, the Maintenance Director agreed that the power strip was unsecured and stated that he would secure the power strip before the end of the day.</p> <p>This finding was reviewed with the Maintenance Director during the exit conference.</p> <p>NFPA 101 Fire Drills Fire Drills</p> <p>1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to:</p> <ul style="list-style-type: none"> a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. <p>2. The facility must:</p> <ul style="list-style-type: none"> a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. <p>3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize.</p> <p>42 CFR 483.470(i)</p> <p>Based on record review and interview, the facility</p>	K S712	The DCCQA tracks all fire drills.	01/17/2024

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

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 01/05/2024
NAME OF PROVIDER OR SUPPLIER CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>failed to conduct evacuation/fire drills at least quarterly for each shift of personnel and under varied conditions for 7 of 12 shifts. This deficient practice affects all staff and clients.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director on 01/05/24 between 10:37 a.m. and 12:00 p.m., the following shifts were missing fire drills:</p> <ul style="list-style-type: none"> a) There was no documentation of a third shift fire drill in the second quarter of 2023 b) There was no documentation of a second or third shift fire drill in the third quarter of 2023 c) There was no documentation for a first shift fire drill in the fourth quarter of 2023 <p>Based on interview at the time of record review, the Maintenance Director stated he was unaware of where the missing fire drills as the only ones he was able to find were in the home. Later on, the Maintenance Director stated that the previous surveyor during the health survey also advised them that they were missing drills which could be why none were found. The Maintenance Director did acknowledge that there were missing fire drills.</p> <p>Findings were discussed with the Maintenance Director at exit conference.</p>		<p>When not completed by the 15th of each month, the Residential Director/QIDP will be notified to rectify the situation. If the situation is not corrected by the end of the month, the manager of the home will receive corrective action. The Residential Director/QIDP will complete the drill before the end of the month to ensure compliance if needed.</p>	