

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

PRINTED: 02/23/2024  
FORM APPROVED  
OMB NO. 0938-0391

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  R 02/20/2024
NAME OF PROVIDER OR SUPPLIER  CORVILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE  52549 MYRTLE ST SOUTH BEND, IN 46637	
(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)
{E 000}	<p>Initial Comments</p> <p>A Post Survey Revisit (PSR) for the Emergency Preparedness Survey that exited on 01/05/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73</p> <p>Survey Date: 02/20/24</p> <p>Facility Number: 000891 Provider Number: 15G377 AIM Number: 100244320</p> <p>At this Emergency Preparedness PSR, Corvilla, Inc. was found 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 7</p> <p>Quality Review completed on 02/22/24</p> <p>INITIAL COMMENTS</p>	{E 000}	
{K 000}	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/05/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).</p> <p>Survey Date: 02/20/24</p> <p>Facility Number: 000891 Provider Number: 15G377 AIM Number: 100244320</p> <p>At this Life Safety Code PSR, Corvilla, Inc. was</p>	{K 000}	

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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NAME OF PROVIDER OR SUPPLIER  <b>CORVILLA INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>52549 MYRTLE ST SOUTH BEND, IN 46637</b>	
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{K 000}	<p>Continued From page 1</p> <p>found 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 7 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 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.44.</p> <p>Quality Review completed on 02/22/24</p>	{K 000}		