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	09/20/2021

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: 09/20/21 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 09/28/21	E 0000		
E 0004 Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	15G377	A. BUILDING -- B. WING	09/20/2021

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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Corvilla	E 0004	The Director of Corporate Compliance/Quality Assurance	10/06/2021

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	Emergency Preparedness Plan (EPP) at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Director of Maintenance on 09/20/21 between 12:15 p.m. and 1:35 p.m., the facility failed to review and update the EPP every two years. The EPP did not have a revision date listed. Based on an interview during records review, the Director of Maintenance agreed no documentation was available to show the EPP was reviewed within the past 2 years. This finding was reviewed with the Director of Maintenance at the time of discovery and again at the exit conference on 09/20/21 at 2:30 p.m.		will review the facilities' emergency preparedness plan every 2 years, as documented by a revision date on each section. This was completed immediately.	
E 0013 Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must			

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	be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Corvilla Emergency Preparedness Plan's (EPP) Policies and Procedures at least every two years in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Director of Maintenance on 09/20/21 between 12:15 p.m. and 1:35 p.m., the EEP lacked a cover page, and no date could be found to show the EPP was reviewed and updated within the last two years. Based on an interview during records review, the Director of Maintenance stated the EPP Policies and Procedures were not updated within the last two years. This finding was reviewed with the Director of Maintenance at the time of discovery and again at the exit conference on 09/20/21 at 2:30 p.m.	E 0013	The Director of Corporate Compliance/Quality Assurance will review the facilities' emergency preparedness plan every 2 years, as documented by a revision date on each section. This was completed immediately.	10/06/2021
E 0029 Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan			

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	§403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the failed to review and update the Corvilla Emergency Preparedness Plan's (EPP) Communication Plan at least every two years in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Director of Maintenance on 09/20/21 between 12:15 p.m. and 1:35 p.m., the EEP lacked a cover page, and no date could be found to show the EPP's Communication Plan was reviewed and updated within the last two years. Based on an interview during records review, the Director of Maintenance stated the EEP Communication Plan was not updated within the last two years. This finding was reviewed with the Director of Maintenance at the time of discovery and again at the exit conference on 09/20/21 at 2:30 p.m.	E 0029	The Director of Corporate Compliance/Quality Assurance will review the facilities' emergency preparedness plan every 2 years, as documented by a revision date on each section. This was completed immediately.	10/06/2021
E 0036 Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d)			

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	EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.			

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	*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed reviewed and updated the Corvilla Emergency Preparedness Plan's (EPP) Training and Testing Plan at least every two years in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Director of Maintenance on 09/20/21 between 12:15 p.m. and 1:35 p.m., the EEP lacked a cover	E 0036	The Director of Corporate Compliance/Quality Assurance will review the facilities' emergency preparedness plan every 2 years, as documented by a revision date on each section. This was completed immediately.	10/06/2021

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	page, and no date could be found to show the EPP's Training and Testing Plan was reviewed and updated within the last two years. Based on an interview during records review, the Director of Maintenance stated the EEP Training and Testing Plan was not reviewed within the last two year period. This finding was reviewed with the Director of Maintenance at the time of discovery and again at the exit conference on 09/20/21 at 2:30 p.m.			
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: 09/20/21 Facility Number: 000891 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, 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.	K 0000		

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	Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 1.52 Quality Review completed on 09/28/21			
K S253 Bldg. 01	NFPA 101 Number of Exits - Patient Sleeping and Non-Sl Number of Exits - Patient Sleeping and Non-Sleeping Rooms 2012 EXISTING (Prompt) Every sleeping room and living area shall have access to a primary means of escape located to provide a safe path of travel to the outside. Where sleeping rooms or living areas are above or below the level of exit discharge, the primary means of escape shall be an interior stair in accordance with 33.2.2.4, an exterior stair, a horizontal exit, or a fire escape stair. In addition to the primary route, each sleeping room shall have a second means of escape that consists of one of the following: 1. It shall be a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape. 2. It shall be a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to approved means of escape. 3. It shall be an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 square feet. The width shall be not less than 20 inches. The height shall be not less than 24			

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	inches. The bottom of the opening shall be not more than 44 inches above the floor. Such means of escape shall be acceptable where one of the following criteria are met: a. The window shall be within 20 feet of finished ground level. b. The window shall be directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction. c. The window or door shall open onto an exterior balcony. 4. Windows having a sill height below the adjacent finished ground level are that provided with a window well meet the following criteria: a. The window well allows the window to be fully openable. b. The window is not less than 9 square feet with a length and width of not less than 36 inches. c. Window well deeper than 43 inches has an approved, permanently affixed ladder or steps complying with the following: 1. The ladder or steps do not extend more than 6 inches into the well. 2. The ladder or steps are not obstructed by the window. 5. If the sleeping room has a door leading directly to the outside of the building with access to finished ground level or to a stairway that meets the requirements of exterior stairs in 33.2.2.2.2, that means of escape shall be considered as meeting all the escape requirements for the sleeping room. a. A second means of escape from each sleeping room shall not be required where the facility is protected throughout by approved automatic sprinkler system in accordance			

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	with 33.2.3.5. b. Existing approved means of escape shall be permitted to continue to be used. 33.2.2.2.1, 33.2.2.2, 33.2.2.3.1 through 33.2.2.3.4 Based on observation and interview, the facility failed to ensure 5 of 6 clients sleeping rooms were provided with a secondary means of escape in accordance with 33.2.2.3. LSC 33.2.2.3 requires a secondary egress from each sleeping room with multiple provisions. This deficient practice could affect 5 of 7 clients. Findings include: Based on observation and interview with the Director of Maintenance during a facility tour on 09/20/21 between 1:35 p.m. and 2:15 p.m. 1 of 6 client sleeping room contained an exterior sliding exit door to the outside of the facility. The remaining bedrooms were equipped only with windows which did not meet the height and area requirements to be considered a second means of escape. The window measurements at the widest point when in the fully opened position are 27.5" W x 20" H for an area of 3.8 SF. This finding and measurements were acknowledged by the Director of Maintenance at the time of discovery and again at the exit conference on 09/20/21 at 2:30 p.m.	K S253	Windows will be removed and Corvilla will add windows that meet the height and area requirements to be considered a second means of escape. This will be completed immediately. This will be completed by Mark Roberts, maintenance director of Corvilla. ="" p=""> ="" p="">	10/13/2021
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70,			

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CORVILLA INC	52549 MYRTLE ST SOUTH BEND, IN 46637

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	National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Director of Maintenance on 09/20/21 between 12:15 p.m. and 1:35 p.m., no documentation was available for review to show if the smoke detector sensitivity had been properly tested within the last two years. Based on provided documentation, the sensitivity test reflected only a visual pass/fail test result. The documentation, from NoBi Fire and Security entitled "Annual Test" dated 12/8/20 and 07/20/21 only showed the manufacturers range for the sensitivities, not the actual point of sensitivity within the ranges where the appliance responded to the sensitivity test. Previous sensitivity tests from 2018 did show the correct reporting. By the end of the survey no	K S345	Corvilla will ensure that fire alarm systems are maintained, which would include checking sensitivity every year if it is a new system, and every two years thereafter. The point sensitivity will be completed immediately. The sensitivity will be checked by Rickey Wooldridge, Maintenance, or Mark Roberts, Director of Maintenance, with Corvilla. ="" p="">	10/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G377	A. BUILDING 01 B. WING	09/20/2021

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

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	documentation of the aforementioned incomplete sensitivity tests was provided. This finding was reviewed with the Director of Maintenance at the time of discovery and again at the exit conference on 09/20/21 at 2:30 p.m.			