

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2014
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NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/21/14</p> <p>Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Chicagoland Christian Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility was located on the west side of the first floor and the entire lower level of a two story building. The facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the</p>	K010000	<p>K 000</p> <p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the revision of federal and state law.</p>	

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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K010025 SS=E	<p>corridors, in spaces open to the corridors and in resident rooms. The facility has a capacity of 144 and had a census of 127 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The detached waste water treatment plant, fire system pump house and equipment storage garages were unsprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/22/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the</p>	K010025	K 025	08/01/2014

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	<p>facility failed to ensure an opening in 1 of 1 lower level corridor ceiling smoke barriers was sealed to maintain the 1/2 hour fire resistance of the smoke barrier. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall, from a floor to a floor, from a a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling including interstitial spaces. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe and other equipment, be protected so the space between the penetrating item and the smoke barrier shall be filled with an approved material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect visitors, staff and 20 or more residents in the kitchen smoke compartment serving the resident dining rooms.</p> <p>Findings include:</p> <p>Based on observation with the maintenance # 1 on 07/21/14 at 12:45 p.m., a three by eight inch ceiling area of the corridor ceiling was cut out around the closing mechanism for the rolling fire shutter protecting the opening between</p>		<p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. No residents or visitors were harmed by this practice.</p> <p>b. Safe Care, the contractor who installed rolling shutter contacted 7/28/14 to return to repair the opening around the closing mechanism.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. Residents, staff and visitors have the potential to be affected.</p> <p>b. The maintenance supervisor will re-check Safe-Care's repair to assure proper work that meets code requirements.</p> <p>3. What measures will be</p>	

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K010044 SS=E	the kitchen and corridor. Maintenance # 1 said at the time of observation, a contractor made the cutout to allow space for the linkage which operated the fire shutter. 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD		<p>put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>a. Maintenance supervisor/designee will audit repair work completed in past six months to assure that no other smoke barriers have been penetrated.</p> <p>b. Ongoing, after any repair work is performed by outside contractors, an inspection will be conducted to assure that LSC 8.3.2 is not been violated. The inspection will be done by the maintenance supervisor/designee</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>a. The maintenance supervisor/designee is responsible for ongoing compliance.</p> <p>b. Any outside contract work will be discussed at QA meeting monthly for six months to assure ongoing compliance.</p>	

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	<p>Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 7 fire door sets were arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect staff, visitors, and 20 or more residents on the Reclaim and Eden Units.</p> <p>Findings include:</p> <p>a. Based on observation with maintenance # 1 on 07/21/14 at 12:15 p.m., one door in the double fire door set separating the Reclaim dining room from the Assisted Living occupancy failed to latch twice when allowed to self close.</p> <p>b. Based on observation with maintenance # 1 on 07/21/14 at 1:35 p.m., one door in the double fire door set separating D hall from the adjacent C hall failed to close and latch when tested twice by allowing the doors to close. The door stuck and left a two inch opening between the doors. The doors failed to</p>	K010044	<p>K 044</p> <p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. No residents or visitors were harmed by this practice.</p> <p>b. D Hall and Reclaim dining room fire doors repaired 7/25/14.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. Residents, staff and visitors have the potential to be affected.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p>	08/01/2014

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	close and latch during a test of the fire alarm system at 2:40 p.m. Maintenance # 1 commented at the time of observations, the doors needed "adjusting." 3.1-19(b)		<p>a. Maintenance supervisor re-checked D Hall and Reclaim fire door repair on 7/28/14 for proper functioning.</p> <p>b. Maintenance supervisor will assign other maintenance staff to observe proper functioning of assigned fire doors during fire drills as of 7/28/14.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>a. The maintenance supervisor/designee is responsible for ongoing compliance.</p> <p>b. Observations of fire doors by maintenance staff will be conducted monthly for compliance.</p> <p>c. Fire drills will be conducted monthly according to assignment by maintenance supervisor for next six(6) months to assure all fire drills are checked.</p> <p>d. Results of the fire drills and proper functioning of fire doors will be reported at monthly QA meetings for compliance.</p>		

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K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen supply storage and transfer rooms was separated by construction with a one hour fire resistant rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)2 requires at least one hour fire-resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. This deficient practice affects staff, visitors and 20 or more residents on the Lower level.</p> <p>Findings include:</p>	K010143	<p>K 143</p> <p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. No residents or visitors were harmed by this practice.</p> <p>2. How other residents</p>	08/01/2014

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	<p>Based on observation with maintenance man # 1 on 07/21/14 at 1:30 p.m., six 181 liter liquid oxygen containers and four e-cylinders were stored in the oxygen storage supply room on the lower level of the facility. The room was identified by maintenance # 1 as the site for the transfer of oxygen from the large containers to portable ones. The lay in tile ceiling was not rated and walls above the lay in ceiling did not continue to the concrete supporting the floor above. An 18 inch gap separated the lay in ceiling from the concrete supporting the floor above. Nothing above the lay in ceiling separated the oxygen storage room from adjacent spaces as evidenced by the visible light around ceiling light fixtures illuminating adjacent rooms and access to lay in ceiling tiles in the adjacent rooms. In addition, three vent ducts were visible above the lay in ceiling. One vented directly to the outside and ran continuously. Maintenance # 1 said at the time of observation, these two ducts ran into other ducts supplying ventilation to other spaces in the building.</p> <p>3.1-19(b)</p>		<p>having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. Residents, staff and visitors have the potential to be affected.</p> <p>b. The corrections being made protect residents, staff and visitors.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>a. Maintenance department personnel initiated work 7/28/14 to remove the present ceiling which doesn't meet NFPA 99.4-3.1.1.2 and replace ceiling with one that is in compliance with one (1) hour fire resistive construction.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>a. The maintenance supervisor/designee is responsible for</p>	

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			<p>ongoing compliance.</p> <p>b. To ensure that this practice does not recur the facility will review Life Safety Code Standards during Quarterly rounds with Administrator.</p> <p>c. Rounds will be discussed at the quarterly Quality Assurance Meeting to ensure compliance with this citation. The change will be in place by August 1, 2014.</p>		