CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPI	LETED
		155637	B. WING		05/17	
		.5555.			33/17	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
1 1 1 1 1	no vident on sorreit.			AST 117TH AVENUE		
CROWN	POINT CHRISTIAN	I VILLAGE	CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	l	I COTION	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
E 0000						
Bldg						
2.49.	An Emergency Prer	paredness Survey was	E 0000	Please consider this plan of		
		diana Department of Health in	L 0000	correction as Crown Point		
	accordance with 42	-		Christian Village's credible pla	an of	
	decordance with 12	CIR 103.73.		correction. This plan of correct		
	Survey Date: 05/17	1/2023		constitutes a written allegation		
	2011.03 Dutc. 03/1/			substantial compliance under		
	Facility Number: 0	01198		Federal and Medicare		
	Provider Number:			requirements. Submission of	thie	
	AIM Number: 100			plan of correction is not an	uiio	
	111111111111111111111111111111111111111	.,1000		admission that a deficiency ex	rists	
	At this Emergency	Preparedness survey, Crown		or that the community agrees		
		age was found not in		were cited correctly. This plan	-	
		nergency Preparedness		correction reflects a desire to	1 01	
	1 -	Sedicare and Medicaid		continuously enhance the qua	ality	
	1 -	lers and Suppliers, 42 CFR		of care and services provided	-	
	483.73	iers and suppliers, 12 of fe		our Residents solely as a	to	
	103.73			requirement of the provision of	of the	
	The facility is certif	fied for 145 beds, and is set up		Federal and State Law. Pleas		
		ven beds are dually certified for		accept this evidence in lieu of		
		caid. Twenty-six are certified		onsite post survey re-visit for	an	
		At the time of the survey, the		recertification and state licens	uro	
	census was 93.	The time of the survey, the		Tecer uncation and state needs	ourc.	
	census was 75.					
	Quality Review con	npleted on 05/22/23				
E 0039	403.748(d)(2), 416	6.54(d)(2), 418.113(d)(2),				
SS=F	, , , ,	2.15(d)(2), 483.475(d)(2),				
Bldg	` ' ' '	102(d)(2), 485.625(d)(2),				
J	1 ' ' ' '	.727(d)(2), 485.920(d)(2),				
		1.12(d)(2), 494.62(d)(2)				
	EP Testing Requir					
		18.113(d)(2), §441.184(d)(2),				
		82.15(d)(2), §483.73(d)(2),				
		484.102(d)(2), §485.68(d)(2),				
		485.727(d)(2), §485.920(d)				
	(2), §491.12(d)(2)					
	(-), 3 10 1.12(\alpha)(2)	, 3.0.02(4)(2).				
	I		I	I		1

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

(X6) DATE

TITLE

Deb Mills Interim Administrator 06/02/2023

Any defiency statement 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 disclodays 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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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 05/17/2023	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	CCTION ULD BE PROPRIATE	(X5) COMPLETION	
TAG	*[For ASCs at §4: OPO, "Organizati CMHCs at §485.9 §491.12, and ESF (2) Testing. The [i exercises to test than unally. The [fact following: (i) Participate in a community-based (A) When a community-based (B) If the [fact natural or man-materistation of the elicis exempt from errommunity-based functional exercis actual event. (ii) Conduct an activation of the elicis exempt from errommunity-based functional exercis actual event. (ii) Conduct an activation every 2 years, op or functional exercis actual event. (i) of this section include, but is not (A) A second full-community-based functional exercis (B) A mock disast (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem states.	rer drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed	TAG	DEFICIENCY		DATE	
(iii) Analyze the [facility's] response to and		1					

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maintain documentation of all drills, tabletop

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		 UILDING	nstruction 	COMPL 05/17/	ETED	
	ROVIDER OR SUPPLIER		6685 EA	ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		nergency events, and revise rgency plan, as needed.				
	the patient's home conduct exercises plan at least annuithe following: (i) Participate in a community based (A) When a community based functional exercises of the emergency exempt from engascale community-facility-based functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a clinically-relevant set of problem star messages, or prepto challenge an error community and considerable and con	spices that provide care in a to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual stional exercise following the gency event. Inditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based exercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed cared questions designed mergency plan.				
	` '	spices that provide inpatient hospice must conduct				

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OJG621 Facility ID: 001198

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CENTERS FOR MEDICARE & MEDICAID SERVICES						ON	MB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	· ′	ESURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING			LETED
		155637	B. W	ING		05/17	7/2023
NAME OF	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
			6685 EAST 117TH AVENUE				
CROWN	I POINT CHRISTIAN	N VILLAGE		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE PRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		he emergency plan twice					
	1	spice must do the following:					
		an annual full-scale exercise					
	that is community						
	, ,	nunity-based exercise is not					
		ict an annual individual					
	_	ctional exercise; or					
	1 ' '	experiences a natural or ency that requires activation					
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event.	_					
	(ii) Conduct an ac	dditional annual exercise					
	that may include,	but is not limited to the					
	following:						
		scale exercise that is					
	-	or a facility based					
	functional exercise						
	(B) A mock disas						
		ercise or workshop led by a					
		udes a group discussion					
	using a narrated,	-					
		rio, and a set of problem ed messages, or prepared					
		ed to challenge an					
	emergency plan.	or to originary arr					
		ospice's response to and					
	· ,	ntation of all drills, tabletop					
		nergency events and revise					
		ergency plan, as needed.					
	-	l41.184(d), Hospitals at					
	§482.15(d), CAHs	- , , -					
	, ,	PRTF, Hospital, CAH] must					
		to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the	tollowing:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 05/17/2023	
	PROVIDER OR SUPPLIEI		6685 E	ADDRESS, CITY, STATE, ZIP COI AST 117TH AVENUE N POINT, IN 46307)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	CTION JLD BE ROPRIATE	(X5) COMPLETION
	that is community					
	accessible, condu	nunity-based exercise is not act an annual individual, ctional exercise; or				
	an actual natural	Hospital, CAH] experiences or man-made emergency				
	plan, the [facility]	ration of the emergency is exempt from engaging in ull-scale community based				
	following the onse	ity-based functional exercise et of the emergency event. an [additional] annual				
	exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is					
	community-based fund	l or individual, a ctional exercise; or				
	(C) A tableto	ock disaster drill; or o exercise or workshop that for and includes a group				
		a narrated, emergency scenario, and a stements, directed				
	messages, or pre to challenge an e	pared questions designed mergency plan.				
	(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. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency					
	plan at least annu organization must (i) Participate in a that is community	t do the following: an annual full-scale exercise				

(A) When a community-based exercise is not

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	ľ	UILDING	NSTRUCTION	(X3) DATE COMPL 05/17	ETED	
	OF PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	facility-based fund (B) If the PACE e or man-made emale activation of the elis exempt from er full-scale community-based functional exercises of this section is of this section in the emergency problem is of this section i	the year the full-scale or e under paragraph (d)(2)(i) conducted that may include, to the following: escale exercise that is a or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. PACE's response to and intation of all drills, tabletop nergency events and revise gency plan, as needed. es at §483.73(d):] ity] must conduct exercises ency plan at least twice per announced staff drills using occedures. The [LTC facility, the following: an annual full-scale exercise						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	l í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL			COMPL	
		155637	B. WING	<u> </u>		05/17/	/2023
NAME OF F	PROVIDER OR SUPPLIER	}			DDRESS, CITY, STATE, ZIP COD		
					AST 117TH AVENUE		
CROWN	POINT CHRISTIAN	VILLAGE		CROWN	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility-based fund						
		ility] facility experiences an					
		nan-made emergency that					
	-	n of the emergency plan, the					
	-	mpt from engaging its next lle community-based or					
	-	based functional exercise					
	-	et of the emergency event.					
	_	dditional annual exercise					
	' '	but is not limited to the					
	following:						
	_	scale exercise that is					
		or an individual, facility					
	based functional e	_					
	(B) A mock disas						
	' '	ercise or workshop that is					
	led by a facilitator	includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er						
		LTC facility] facility's					
	•	naintain documentation of					
	· ·	exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	5483.475(d)]:					
		CF/IID must conduct					
		he emergency plan at least					
		e ICF/IID must do the					
	following:						
	(i) Participate in a	n annual full-scale exercise					
	that is community-based; or						
	(A) When a community-based exercise is not						
	accessible, conduct an annual individual,						
	facility-based fund	ctional exercise; or.					
	(B) If the ICF/IID experiences an actual						

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natural or man-made emergency that requires

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ENTERS FO	ARTMENT OF HEALTH AND HUMAN SERVICES TERS FOR MEDICARE & MEDICAID SERVICES						
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637		JILDING	ONSTRUCTION	(X3) DATE COMPI 05/17	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE				
CROWN	I POINT CHRISTIAN	N VILLAGE		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF COR			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	activation of the e is exempt from en full-scale commun facility-based functions onset of the emer (ii) Conduct an add that may include, following: (A) A second full-scommunity-based facility-based function (B) A mock disast (C) A tabletop exeled by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an endition of the ICF/IID's emethology and entitle ICF/IID's entitle ICF/IID	emergency plan, the ICF/IID agaging in its next required nity-based or individual, ctional exercise following the gency event. Iditional annual exercise but is not limited to the scale exercise that is I or an individual, ctional exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. CF/IID's response to and intation of all drills, tabletop in ergency events, and revise regency plan, as needed. 84.102] e HHA must conduct the emergency plan at the HHA must do the full-scale exercise that is It; or community-based exercise conduct an annual chased functional exercise					
	every 2 years; or. (B) If the HH	A experiences an actual					

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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,

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637			UILDING	nstruction 	COMPI 05/17	LETED	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE		
CROWN	POINT CHRISTIAN	N VILLAGE			N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1710		tional exercise following the		1110			DITTE
	onset of the emer						
		ditional exercise every 2					
	, ,	e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c						
	include, but is not	limited to the following:					
	(A) A second	full-scale exercise that is					
	community-based	or an individual,					
	facility-based fund	ctional exercise; or					
	(B) A mock di	isaster drill; or					
	, , ,	exercise or workshop that					
	is led by a facilitat	or and includes a group					
	discussion, using						
	_	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
		HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the HHA's emerge	ency plan, as needed.					
	*[For OPOs at §48	-					
	` ' ' '	e OPO must conduct					
		he emergency plan. The					
	OPO must do the	_					
		er-based, tabletop exercise					
		ast annually. A tabletop					
		a facilitator and includes a					
		using a narrated, clinically					
		cy scenario, and a set of					
	I *	nts, directed messages, or ns designed to challenge an					
		f the OPO experiences an					
		nan-made emergency that					
		nan-made emergency that n of the emergency plan, the					
		om engaging in its next					
		xercise following the onset					
	of the emergency	_					
	1		- 1				I

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DEPARTMEN CENTERS FO		FORM APPROVED OMB NO. 0938-039				
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	(X2) MULTI A. BUILDI B. WING	IPLE CONSTRUCTION ING <u></u>	(X3) DA	TE SURVEY MPLETED 17/2023
	PROVIDER OR SUPPLIEI		66	TREET ADDRESS, CITY, STATE, ZIP CO 685 EAST 117TH AVENUE ROWN POINT, IN 46307)D	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		II. PRE TA	FIX (EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	exercises to test to RNHCI must do to the RNHCI must do to the control of the community of the emergency promengaging its not community-based of the emergency promengaging its not community promengaging its	the energency plan. The me following: er-based, tabletop exercise is a led by a facilitator, using a verelevant emergency et of problem statements, es, or prepared questions enge an emergency plan. NHCl's response to and intation of all tabletop mergency events, and revise regency plan, as needed. View and interview, the facility emplete documentation for the ity-based exercises to test the edness Plan (EPP). The state of the following: annual full-scale exercise that dispersions of the exercise is not an annual individual,	E 0039	It is the policy of Crow Christian Village to fol federal, state and loca guidelines, laws and s This plan of correction be construed as an ad of deficient practice by facility manager, empl agents or other individed the response to the all insufficient practice of this statement does not constitute agreement insufficiency. The prepulse submission and implementation of this	low all I tatutes. I is not to mission y the oyee, duals. lleged ited in ot with the paration,	06/17/2023

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the onset of the actual event.

(ii) Conduct an additional exercise that may

include, but is not limited to the following:

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correction will serve as

credible allegation of

compliance.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		lì í	ULTIPLE CO UILDING ING	(X3) DATE SURVEY COMPLETED 05/17/2023				
		PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307				
	4) ID EFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
PR		(EACH DEFICIENT REGULATORY OF a. A second full-sear community-based of functional exercise. b. A mock disaster c. A tabletop exercifacilitator that incluse a narrated, clinically and a set of problem messages, or prepare challenge an emerg (iii) Analyze the LT maintain document exercises, and emer LTC facility's emer accordance with 42 deficient practice of Findings include: Based on records red Director on 05/17/2 p.m., a table-top exercises, but no docommunity-based of be provided at the terms.	drill; or use or workshop that is led by a use a group discussion, using y-relevant emergency scenario, an statements, directed red questions designed to ency plan. TC facility's response to and ation of all drills, tabletop regency events, and revise the regency plan, as needed in CFR 483.73(d)(2). This bould affect all occupants.			(EACH CORRECTIVE ACTION SHOULD BE	completion DATE ere d to esed r d le al to li f to to	
		Maintenance Director stated he was unsure whether the facility had conducted a community or facility-based exercise within the past year and was unable to be provide documentation during record review. This finding was reviewed with the Maintenance Director and the Executive Director during the exit conference.				Plan. Quality Assurance Plans to monitor facility performance ensure corrections are achieved and deficient practivity will not recur: Findings of the two annual exercises will be reported to to QAPI Committee for one year The QAPI Committee will determine the need for continuor additional corrective action maintain compliance.	e to tice the r. ued	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/17/2023	
	PROVIDER OR SUPPLIE			6685 E	ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
E 0041 SS=F Bldg	§482.15(e) Condi (e) Emergency ar The hospital mus standby power sy emergency plan s this section and in procedures plan s (i) and (ii) of this s §483.73(e), §485 (e) Emergency ar The [LTC facility a implement emerg systems based or forth in paragraph §482.15(e)(1), §4 Emergency gene generator must b the location requi Care Facilities Co Interim Amendme 12-4, TIA 12-5, at Code (NFPA 101 Amendments TIA and TIA 12-4), an structure is built of structure or buildi 482.15(e)(2), §48 Emergency gene The [hospital, CA implement the en inspection, testing requirements four	d LTC Emergency Power Ition for Participation: Ind standby power systems. It implement emergency and itstems based on the set forth in paragraph (a) of in the policies and set forth in paragraphs (b)(1) section. Industry the section of the policies and set forth in paragraphs (b)(1) section. Industry the section of the emergency plan set in (a) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency plan set in (a) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency plan set in (b) of this section. Industry the emergency pla					

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	EMENT OF DEFICIENCIES LAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	l í	ILDING	NSTRUCTION	(X3) DATE COMPI 05/17	ETED		
	OF PROVIDER OR SUPPLIES			STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307					
(X4) II PREFI TAG	X (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE		
	Emergency general and LTC facilities source to power of have a plan for he power systems of emergency, unless *[For hospitals at §483.73(g), and the standards independent of this section are at reference by the least Federal Register 552(a) and 1 CFF the material from You may inspect Information Reso Boulevard, Baltim Archives and Rece (NARA). For inforthis material at Narago to: http://www.archiv.of_federal_regul If any changes in incorporated by redocument in the Feannounce the characteristic (1) National Fire Featterymarch Par Quincy, MA 0216 1.617.770.3000. (i) NFPA 99, Hea 2012 edition, issued (iii) Technical inter NFPA 99, issued (iii) TIA 12-3 to Ni 2012.	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in pproved for incorporation by Director of the Office of the in accordance with 5 U.S.C. R part 51. You may obtain the sources listed below. a copy at the CMS urce Center, 7500 Security nore, MD or at the National cords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code lations/ibr_locations.html. this edition of the Code are eference, CMS will publish a Federal Register to anges. Protection Association, 1 rk, 9, www.nfpa.org, Ith Care Facilities Code, and August 11, 2011. rim amendment (TIA) 12-2 to							

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/17/2023	
	PROVIDER OR SUPPLIEI		6685	FADDRESS, CITY, STATE, ZIP COD EAST 117TH AVENUE VN POINT, IN 46307	(V5)	
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	2013. (vi) TIA 12-6 to NI 2014. (vii) NFPA 101, Lie edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NI 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NI 22, 2013. (xii) NFPA 110, S Standby Power S including TIAs to 2009. Based on records refailed to implement requirements found Code, NFPA 110, a accordance with 42 deficient practice of Findings include: Based on records repuired by LSC are interview at the tim Maintenance Director of the required 4-he further stated that the conducted within the stated within the stat	FPA 101, issued August FPA 101, issued October FPA 102, issued October FPA 103, issued October FPA 104, issued October FPA 105, issued October FPA 105, issued October FPA 106, issued October FPA 106, issued October FPA 107, issued October FPA 107, issued October FPA 108, issued October FPA 108, issued October FPA 109, issued October FPA 101, issued October FPA 102, issued October FPA 103, issued October FPA 103, issued October FPA 104, issued October FPA 101, issued October FPA 102, issued October FPA 103, issued October FPA 104, issued October FPA 106, issued October FPA 107, issued October FPA 107, issued October FPA 107, issued October FPA 108, issued October FPA 108, issued October FPA 107, issued October FPA 108, issued October FPA 108, issued October FPA 103, issued October FPA 103, issued October FPA 103, issued October FPA 104, issued October FPA 103, issued October FPA 103	E 0041	E041 Corrective actions which we done for the residents found have been affected by the deficient practice: A four-hour continuous run un load test for the emergency generator was conducted 6/1/Also, a diesel generator fuel quality test was completed by vendor 5/31/23; awaiting resulting the potential to be affected by the same deficient practice: All residents have the potential be affected. The measures the facility will take and systems the facility	oder /23; //ts. ne al to	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/17/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	Director and Mainte conference.	enance Director at the exit		will alter to ensure that the deficient practice will not reoccur: A four-hour continuous run u load test for the emergency generator will be scheduled a 36 months with documentatic and a diesel generator fuel q test will be scheduled annual with documentation in the woorder system. Quality Assurance Plans to monitor facility performance ensure corrections are achieved and deficient practices and 36-month generatests findings will be reported QAPI Committee. The QAPI Committee will determine the for continued or additional corrective actions to maintain compliance.	every on uality tly, ork e to tice ator t to			
K 0000								
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 05/17 Facility Number: 0 Provider Number: 1004	01198 155637	K 0000	Please consider this plan of correction as Crown Point Christian Village's credible please correction. This plan of corrections a written allegation substantial compliance under Federal and Medicare requirements. Submission of plan of correction is not an admission that a deficiency error that the community agrees were cited correctly. This plan	ction on of this exists s they			

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/17/2023	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION vas found not in compliance		TAG	correction reflects a desire to		DATE	
	with Requirements	•			continuously enhance the qua	-		
		l, 42 CFR Subpart 483.90(a),			of care and services provided	to		
	I -	re and the 2012 edition of the			our Residents solely as a			
		ction Association (NFPA) 101,			requirement of the provision of			
		LSC), Chapter 19, Existing ancies and 410 IAC 16.2.			Federal and State Law. Please accept this evidence in lieu of			
	Treatur Care Occup.	ancies and 410 IAC 10.2.			onsite post survey re-visit for	all		
	This facility was lo	cated on the west side of the			recertification and state license	ıre		
	· ·	ntire lower level of a two story			recentification and state floories	u10.		
		ity was determined to be of						
	_	ruction and was fully						
	sprinklered. The H	ealthcare Occupancy includes						
	the atrium area of the	he second floor as it was not						
		hour barrier. No residents use						
		he facility has a fire alarm						
	1 -	rired smoke detection in the						
	·	open to the corridors and						
		tation detectors in resident						
		ng is protected by a 150 kW						
		erator which provides						
		The facility is certified for 145						
		for 144. Eighty-seven beds are Medicare and Medicaid.						
	1	ified for Medicare only. At the						
	time of the survey,	-						
	time of the survey,	the census was 73.						
	All areas where the	residents have customary						
		ered. The detached waste						
	_	nt, fire system pump house and						
	equipment storage	garages were unsprinklered.						
	Quality Review con	mpleted on 05/22/23						
K 0345	NFPA 101							
SS=F	Fire Alarm Systen	n - Testing and						
Bldg. 01	Maintenance	-						
	Fire Alarm Systen	n - Testing and						
	Maintenance							
	A fire alarm syste	m is tested and maintained						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155637	B. W	ING		05/17	/2023
		1	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			AST 117TH AVENUE		
CROWN	POINT CHRISTIAN	N VILLAGE	_	CROWN POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΛΤΕ.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		h an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
		m and Signaling Code.					
		m acceptance, maintenance					
	and testing are re	<u> </u>					
		IFPA 70, NFPA 72	17.0	2.45	150.4		06/17/2022
		review and interview, the	K 0	345	K345		06/17/2023
		sure 1 of 1 fire alarm systems accordance with LSC 9.6.1.3.			Corrective actions which we	_	
					done for the residents found	το	
	_	es a fire alarm system to be d maintained in accordance			have been affected by the		
		tional Electrical Code and NFPA			deficient practice:	.4	
		larm Code. NFPA 72, Section			Smoke detector sensitivity tes		
		s otherwise permitted by other			completed with documentation	1	
		de, testing shall be performed			6/1/23; Annual fire alarm		
		the schedules in Table 14.4.5,			inspection completed 6/1/23-awaiting report; Painter	r'o	
		quired by the authority having			tape removed from identified	1 3	
		A 72, Section 14.4.5.3.1 states			smoke detector upon discover	n/	
	-	sitivity shall be checked within			5/17/23.	У	
		tion. NFPA 72, 14.4.5.3.2 states			How the facility will identify		
	-	sitivity shall be checked every			other residents having the		
		after unless otherwise			potential to be affected by th	ie.	
		liance with Section 14.4.5.3.3.			same deficient practice:		
		tice could affect all occupants.			All residents have the potentia	al to	
					be affected.		
	Findings include:				The measures the facility wil	11	
					take and systems the facility		1
	Based on record re	view with the Maintenance			will alter to ensure that the		
	Director on 05/17/2	23 between 10:01 a.m. and 12:52			deficient practice will not		
		ation for a smoke detector			reoccur:		1
	_	available for review. Based on			1.Smoke detector sensitivity to	est	
		ne of record review, the			scheduled with documentation		
	Maintenance Direc	tor acknowledged the			every two years, in the work o	rder	
		ndition and confirmed no other			system; 2. Fire alarm system		
	documentation was	available for review.			visual inspection scheduled		
					semi-annually with documenta	ation	
	This finding was re	eviewed with the Maintenance			in the work order system; 3.		
		tive Director at exit conference.			Annual fire alarm inspection		
	3.1-19(b)				scheduled with documented		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/17/2023	
	PROVIDER OR SUPPLIER	<u> </u>	STREET . 6685 E	ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE IN POINT, IN 46307	132020
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION
TAG	2. Based on record facility failed to ma in accordance with 101 Sections 19.3.4 14.3.1 states that ur 14.3.2, visual insperaccordance with the more often if requiripurisdiction. Table must be visually insa. Control unit troub. Remote annunciate. Initiating devices fire alarm boxes, he etc.) d. Notification apple. Magnetic hold-op This deficient practifacility. Findings include: During records reviron Director on 05/17/2 p.m., no documentate visual inspection of months prior to the Based on interview the Maintenance Diaforementioned consemi-annual inspection.	eters (e.g. duct detectors, manual cat detectors, smoke detectors, siances been devices ice affects all occupants in the ew with the Maintenance 3 between 10:01 a.m. and 12:52 ation was provided regarding a the fire alarm system six annual fire alarm inspection. at the time of records review, rector acknowledged the	TAG	inspection report; 4. Smoke detectors to be inspected at lea quarterly for anything covering detectors. Quality Assurance Plans to monitor facility performance ensure corrections are achieved and deficient practi will not recur: Findings will be reported quart to the QAPI Committee for 6 months. The QAPI Committee will determine the need for continued or additional correct actions to maintain compliance.	ast to ce erly e
	3. Based on record	review and interview, the			

facility failed to ensure 1 of 1 fire alarm systems

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	OF CORRECTION	IDENTIFICATION NUMBER 155637				COMPL 05/17/	ETED
	PROVIDER OR SUPPLIER			6685 EA	ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE	
	LSC 9.6.1.3 require installed, tested, and with NFPA 70, Nat 72, National Fire A 14.2.1.2.2 requires a malfunctions shall be practice could affect Findings include: Based on record revelopments of the survey. It is a state of the survey. It is a state of the survey. It is a state of the survey of the facility at the time of documentation could the survey. This finding was reduced by the survey. It is a state of the su	riew with the Maintenance 3 between 10:01 a.m. and 12:52 in for an annual fire alarm as unable to be located at the Based on an interview at the tw, the Maintenance Director contacted the alarm company orwarded the report to the of the survey and agreed d not be provided. viewed with the Maintenance tive Director during the exit review, observation and ty failed to ensure 1 of 1 fire maintained in accordance with Fire Alarm and Signaling Code. tion, 14.2.1.2.1 states the etion 10.19 shall be applicable apaired. Section 14.2.1.2.2 as and malfunctions shall be dicient practice could affect all					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637			JILDING	nstruction 01	(X3) DATE COMPL 05/17 /	ETED		
	ROVIDER OR SUPPLIER POINT CHRISTIAN			STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
K 0353 SS=F Bldg. 01	with the Maintenand between 12:55 p.m. smoke detector local near resident room 2 the smoke detector. operation of the fire Upon interview at the Maintenance Direct of the covered smoke removed at observation of the covered smoker and Executed 3.1-19(b) NFPA 101 Sprinkler System - Sprinkler System - Automatic sprinkler are inspected, test accordance with New Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAF coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8,	Assed with the Maintenance tive Director at exit conference. - Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, etting are maintained in a readily available. It is system last checked - system test - supply source - RKS information on non-required or partial or system.	K 0	353	K353		06/17/2023	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 05/17/2023 155637 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6685 EAST 117TH AVENUE CROWN POINT CHRISTIAN VILLAGE CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE facility failed to maintain 1 of 1 sprinkler system in Corrective actions which were accordance with LSC 9.7.5. LSC 9.7.5 requires all done for the residents found to automatic sprinkler systems shall be inspected have been affected by the and maintained in accordance with NFPA 25, deficient practice: Standard for the Inspection, Testing, and A wet pipe sprinkler system Maintenance of Water-Based Fire Protection gauges and valves inspection was Systems. NFPA 25, 2011 edition, Table 5.1.1.2 completed with documentation indicates the required frequency of inspection and 5/30/23; a quarterly sprinkler testing. NFPA 25, 5.2.4.1 states gauges on wet system inspection is scheduled pipe sprinkler systems shall be inspected monthly for 6/9/23, during which the and gauges on dry systems (5.2.4.2) shall be 2/18/23 quarterly inspection inspected weekly to ensure normal water or air identified deficiencies will be pressure is being maintained. NFPA 25 13.3.2.1 corrected including, the sprinkler states valves should be inspected weekly or system supervisory switch valves secured locks or supervised (13.3.2.1.1) repair; a legible sprinkler riser shall be permitted to be inspected monthly. This hydraulic nameplate was securely, deficient practice could affect all occupants. attached 6/2/23. How the facility will identify Findings include: other residents having the potential to be affected by the Based on records review with the Maintenance same deficient practice: Director on 05/17/23 between 10:01 a.m. and 12:52 All residents have the potential to p.m., there was no monthly inspection of the wet be affected. pipe sprinkler system's gauges and valves for the past 12 months. During an interview at the time of The measures the facility will record review, the Maintenance Director stated take and systems the facility inspections are usually visual and not written will alter to ensure that the down on record. deficient practice will not reoccur: Findings were discussed with the Executive Monthly wet pipe sprinkler system Director and Maintenance Director at exit gauges and valves inspections are conference. scheduled with documentation, in the work order system; any future, 3.1-19(b) quarterly sprinkler system inspection deficiencies will be 2. Based on record review and interview, the timely corrected. facility failed to maintain 1 of 1 automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 **Quality Assurance Plans to** requires all sprinkler systems shall be inspected, monitor facility performance to

tested, and maintained in accordance with NFPA

ensure corrections are

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	(X2) MULTIPLE A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 05/17/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION DATE			
	Maintenance of Wa Systems. NFPA 25 states the property of representative shall or impairments that inspection, test and standard. Correction performed by qualified contractor records shall be made available in many and maintenance of shall be made available jurisdiction upon recould affect all residuality. Findings include: Based on records requarterly Inspection 02/08/23 with Main between 10:01 a.m. deficiency recap on noted that the hydrasprinkler riser was a attached to the riser deficiencies were not for the sprinkler system attached to the riser deficiencies were not the sprinkler system last inspection on 0 also noted in sprink 08/04/22. Findings were discussed.	e Inspection, Testing, and ter-Based Fire Protection (2011 Edition, Section 4.1.4.1) owner or designated correct or repair deficiencies are found during the maintenance required by this ons and repairs shall be fied maintenance personnel or or. NFPA 25, 4.3.1 requires de for all inspections, tests, of the system components and able to the authority having quest. This deficient practice dents, staff, and visitors in the service of "Sprinkler Inspection - no" documentation dated attenance Director on 05/17/23 and 12:52 p.m., under the page four of the report, it was nulic nameplate for the not legible and securely at Furthermore, two other coted. The supervisory switch stem did not pass testing. The time of record review, rector acknowledged there are the time of record review, rector acknowledged there are the deficiencies were ler reports from 11/02/22 and assed with the Maintenance tive Director at exit conference.		achieved and deficient prawill not recur: Monthly & quarterly inspect findings will be report to the Committee for 6 months. To QAPI Committee will determ the need for continued or additional corrective actions maintain compliance.	ions QAPI he nine			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 05/17/2023				ETED	
	PROVIDER OR SUPPLIER			6685 EA	ODDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0363 SS=D Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. The apply to auxiliary solid flammable or come Clearance between covering is not except to a complying with the door closed with a complete covering of the door release when the permitted. Nonrate unlimited height at meeting 19.3.6.3.6 frames shall be lated to the materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restricts.	rials have positive latching atches are prohibited by these requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPL	ETED
		155637	B. W	ING		05/17/2023	
				CTREET	ADDRESS OF A TE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE		
CDOWN	CROWN POINT CHRISTIAN VILLAGE						
CROWN POINT CHRISTIAN VILLAGE				CROWN POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	19.3.6.3, 42 CFR	Parts 403, 418, 460, 482,					
	483, and 485						
	Show in REMARK	(S details of doors such as					
	fire protection ration	ngs, automatics closing					
	devices, etc.						
	Based on observation	on and interview, the facility	K 0	363	K363		06/17/2023
	failed to ensure 2 of	f 17 resident room corridor			Corrective actions which wei	re	
	doors on the southw	vest wing were provided with			done for the residents found	to	
	a means suitable for	r keeping the door closed, had			have been affected by the		
	_	losing, latching and would			deficient practice:		
		f smoke. This deficient			Both affected door latches we	re	
	•	et 4 residents in rooms 275 and			adjusted to properly function.	All	
	278.				resident room corridor doors w	/ere	
					inspected by maintenance		
	Findings include:				5/25/23.		
		on with the Maintenance			How the facility will identify		
		3 between 12:55 p.m. and 2:45			other residents having the		
	-	oor to resident rooms 275 and			potential to be affected by th	е	
		to the frame when tested three		same deficient practice:			
		erview at the time of		All residents have the potential to		l to	
		nintenance Director agreed			be affected.		
		to latch into the frame. The				_	
		be adjusted at the time of			The measures the facility wil		
	observation.				take and systems the facility		
	Th. C. 1	iidid.d. E			will alter to ensure that the		
	_	viewed with the Executive			deficient practice will not		
		aintenance Director during the			reoccur:		
	exit conference.				All resident room corridor door		
	2.1.10/1				will be inspected and adjusted	•	
	3.1-19(b)				necessary) monthly and sched	iuled	
					in work order system.		
					Quality Assurance Plans to		
					monitor facility performance	to	
					ensure corrections are	.0	
					achieved and deficient practi	CO	
					will not recur:	UG.	
					Maintenance staff to monthly		
					monitor, log, repair/adjust as		
					monitor, roy, repair/aujust as		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILD 155637 B. WING	PLE CONSTRUCTION (X3) DATE SURVEY ING 01 COMPLETED 05/17/2023
155637 B. WING	05/17/2023
NAME OF PROVIDER OR SUPPLIER 66	REET ADDRESS, CITY, STATE, ZIP COD 685 EAST 117TH AVENUE ROWN POINT, IN 46307
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE II PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE	PROVIDER'S PLAN OF CORRECTION
	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE
	needed and report findings monthly to QAPI Committee for 6 months. The QAPI Committee will determine the need for continued or additional corrective actions to maintain compliance.
K 0712 NFPA 101	
SS=F Fire Drills	
Bldg. 01 Fire Drills	
Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	
Based on record review and interview, the facility failed to conduct fire drills on each shift for 4 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents.	Corrective actions which were done for the residents found to have been affected by the deficient practice: Identified 12 missing fire drills documentation was located in a different office, after the survey.
Findings include: Based on records review with the Maintenance	How the facility will identify other residents having the potential to be affected by the same deficient practice:
Director on 05/17/23 between 10:01 a.m. and 12:52 p.m., all 12 required fire drill documentation was	All residents have the potential to be affected.
unable to be located. Based on interview at the	
time of record review, the Maintenance Director	The measures the facility will

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stated that all fire drills are documented in a

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take and systems the facility

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/17/2023		
NAME OF PROVIDER OR SUPPLIER CROWN POINT CHRISTIAN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)		ГЕ	(X5) COMPLETION DATE	
	computer software the binder containing could not be found of Findings were discurbined and Execute 3.1-19(b) 3.1-51(c)	TELS' and handwritten, but g all of the documentation			will alter to ensure that the deficient practice will not reoccur: Regularly scheduled & documented fire drills will cont and be retained in a Maintena Office binder. Quality Assurance Plans to monitor facility performance ensure corrections are achieved and deficient practi will not recur: Fire drills summary will be reported monthly to QAPI Committee for 6 months. The QAPI Committee will determin the need for continued or additional corrective actions to maintain compliance.	to ce	
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and when anesthesia is adminitial installation, and defined by document Receptacles not list these locations are exceeding 12 mor (LIM), if installed, alless than or equal the LIM test switch activates both visual restings.	s - Maintenance and s - Maintenance and ceptacles at patient bed cre deep sedation or general cinistered, are tested after replacement or servicing. cis performed at intervals cented performance data. cented as hospital-grade at ce tested at intervals not centered at intervals of centered at int					

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 05/17/2023 155637 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6685 EAST 117TH AVENUE CROWN POINT CHRISTIAN VILLAGE CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and K 0914 K914 06/17/2023 interview, the facility failed to ensure non-hospital Corrective actions which were grade electrical receptacles at 86 of 86 resident done for the residents found to sleeping rooms were tested at least annually. have been affected by the NFPA 99, Health Care Facilities Code 2012 Edition, deficient practice: Section 6.3.4.1.3 states receptacles not listed as All identified resident room hospital-grade, at patient bed locations and in non-hospital-grade electrical locations where deep sedation or general receptacles were numbered and anesthesia is administered, shall be tested at tested 5/26, 5/30, 5/31/23. intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care How the facility will identify Rooms requires the physical integrity of each other residents having the receptacle shall be confirmed by visual inspection. potential to be affected by the The continuity of the grounding circuit in each same deficient practice: electrical receptacle shall be verified. Correct All residents have the potential to polarity of the hot and neutral connections in be affected. each electrical receptacle shall be confirmed; and retention force of the grounding blade of each The measures the facility will electrical receptacle (except locking-type take and systems the facility receptacles) shall be not less than 115 grams (4 will alter to ensure that the ounces). This deficient practice could affect all deficient practice will not residents. reoccur: All identified resident room, Findings include: non-hospital-grade electrical receptacles were numbered and Based on observations during a tour of the facility scheduled for annual testing with a with the Maintenance Director on 05/17/23 documentation log in the work between 12:55 p.m. and 2:45 p.m., the facility's 86 order system. resident sleeping rooms contained four to eight

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non-hospital-grade electrical receptacles. Based

on records review between 10:01 a.m. and 12:52

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Quality Assurance Plans to

monitor facility performance to

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		î ´	UILDING	onstruction 01	(X3) DATE COMPL 05/17 /	ETED			
NAME OF PROVIDER OR SUPPLIER CROWN POINT CHRISTIAN VILLAGE				STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
p.m., no documentation was available to show electrical receptacles in resident sleeping rooms were tested annually. Based on interview at the time of the observation and records review, the Maintenance Director confirmed all of the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated annual testing per NFPA 99, Receptacle Testing requirements has not been completed.				ensure corrections are achieved and deficient practice will not recur: Annual findings will be reported to QAPI Committee. The QAPI Committee will determine the need for continued or additional corrective actions to maintain compliance.					
	Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)								
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are cor personnel. Mainte energy power sou	other alternate power lated equipment is capable be within 10 seconds. If the in is not met during the posess shall be provided to his capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised in the for 4 continuous hours. It is defined to the continuous hours.							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		155637	B. WI	NG		05/17	/2023
NAME OF PROVIDER OR SUPPLIER CROWN POINT CHRISTIAN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	(X5) COMPLETION DATE
	circuit breakers a program for perio components is es manufacturer req of maintenance a and readily availa and circuits are mand separate from Minimizing the poemergency power consideration for 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.1 1. Based on record facility failed to mast standard for Emerg Systems, Section 8 Health Care Facility NFPA 110 Section Emergency Power once within every the assigned class is grapher permitted to terming NFPA 99 Section 6 Type 2 essential elesthall be classified a generator sets. This affect all building of Findings include: During records rev Director on 05/17/2 p.m., documentation emergency generate months was not prointerview at the time Maintenance Director on Di	re inspected annually, and a dically exercising the tablished according to uirements. Written records and testing are maintained ble. EES electrical panels tarked, readily identifiable, an normal power circuits. It is sibility of damage of the resource is a design anew installations. (NFPA 99), NFPA 110, 00 (NFPA 70) review and interview, the aintain 1 of 1 Emergency Power accordance with NFPA 110, gency and Standby Power 4.9, as required by NFPA 99 ies Code, Section 6.4.1.1.6.1. 8.4.9 states that all Level 1 Systems shall be tested at least three years. Where the eater than 4 hours, it shall be tate the test after 4 hours. 6.4.1.1.6.1 states that Type 1 and exercical system power sources at Type 10, Class X, Level 1 is deficient practice could	K 0º		K918 Corrective actions which we done for the residents found have been affected by the deficient practice: A four-hour continuous run ur load test for the emergency generator was conducted with documentation 6/1/23; Also, a diesel generator fuel quality to was completed with documentation 5/31/23; await results. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential be affected. The measures the facility will alter to ensure that the deficient practice will not reoccur: A four-hour continuous run ur	to to ander the sest ting	06/17/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 05/17/2023						
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307					
	SUMMARY SUMMARY SEACH DEFICIEN REGULATORY OR the past 36 months. This finding was reducted by the past 36 months. This finding was reducted by the past 36 months. This finding was reducted by the past 36 months. This finding was reducted by the past 36 months. 3.1-19(b) 2. Based on record of facility failed to ensure was performed for 18 generator. NFPA 9 2012 Edition Section (Essential Electrical be inspected and test Section 6.4.4.1.1.3. maintenance shall be with NFPA110, Standby Power System NFPA 110, Section shall be performed as the past of	TVILLAGE STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION Eviewed with the Executive enance Director at the exit The state of 1 facility's diesel powered 10, Health Care Facilities Code, 11, 12 states Type 2 EES 11 System) generator sets shall 12 sted in accordance with 13 sted in accordance with 15 section 6.4.4.1.1.3 states 16 performed in accordance 17 states a fuel quality test 18 states a fuel quality test 18 states a fuel quality test 19 states annually using tests 19 standards. This deficient	6685	EAST 117TH AVENUE	BE COMPLETION DATE / devery tion quality really, work to nice to actice erator eed to Pl he need			
	Director on 05/17/2 p.m., no documenta test for the diesel ge review. Based on in review, the Mainten facility does have a unaware of the fuel and did not have the Maintenance Direct analysis had not becayear.	view with the Maintenance 3 between 10:01 a.m. and 12:52 tion of an annual fuel quality enerator was available for terview at the time of records nance Director stated the diesel generator but was quality testing requirements e fuel tested. The or later confirmed that a fuel en performed within the past						

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AND PLAIN	JF CORRECTION	IDENTIFICATION NUMBER 155637	B. WI		<u>01</u>	05/17/		
			Ь,	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER		6685 EAST 117TH AVENUE					
CROWN	POINT CHRISTIAN	I VILLAGE		CROWN POINT, IN 46307				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	-	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION]	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE	
1110		enance Director at the exit		1110			DITTE	
	conference.							
	3.1-19(b)							
K 0920	NFPA 101	1 Dawn Oanda and						
SS=D Bldg. 01	Electrical Equipme	ent - Power Cords and						
Diag. 01		ent - Power Cords and						
	Extension Cords							
		patient care vicinity are only						
	used for compone							
		ed electrical equipment						
	, ,	les that have been						
	• •	alified personnel and meet						
		10.2.3.6. Power strips in						
		cinity may not be used for , personal electronics),						
	, -	n care resident rooms that						
		E. Power strips for PCREE						
		r UL 60601-1. Power strips						
		the patient care rooms						
		r) meet UL 1363. In						
		ooms, power strips meet						
	-	ls. All power strips are						
	used with general	precautions. Extension						
		d as a substitute for fixed						
		re. Extension cords used						
		moved immediately upon						
	-	purpose for which it was						
		ts the conditions of 10.2.4.						
		9), 10.2.4 (NFPA 99), 400-8						
	, , , , , , , , , , , , , , , , , , , ,	(D) (NFPA 70), TIA 12-5 on and interview, the facility	K 09	220	K920		06/17/2023	
		f 1 power strips were not used	IN U5	120	Corrective actions which we	ro	00/1//2023	
		ixed wiring to provide power			done for the residents found			
	equipment with a hi				have been affected by the			
		0.8 state unless specifically			deficient practice:			
	permitted in 400.7 f	flexible cords and cables shall			Identified refrigerator and			
	not be used for (1) a	as a substitute for fixed wiring.			microwave were removed. An			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155637		155637	B. WING			05/17/2023	
NAME OF PROVIDER OR SUPPLIER CROWN POINT CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	16	DATE
	This deficient practice could affect approximately				inspection was conducted for		
	15 staff and residents.				prohibited extension cords and	d	
					power strip use 5/25/23.		
	Findings include:						
					How the facility will identify		
	Based on observation	ons during a tour of the facility			other residents having the		
	with the Maintenan	ce Director on 05/17/23			potential to be affected by th	е	
	_	and 2:45 p.m., a refrigerator			same deficient practice:		
	(high power draw equipment) and microwave				All residents and offices have	the	
	(high power draw equipment) was plugged into				potential to be affected.		
	and supplied power by a power strip in the Social						
	Services office near room 265. Based on interview				The measures the facility wil		
	at the time of observation, the Maintenance				take and systems the facility		
		lged power strip was supplying			will alter to ensure that the		
		ower appliances and would			deficient practice will not		
	take care of the issu	ie.			reoccur:		
					Monthly rounding inspections		
	Findings were discussed with the Maintenance				prohibited extension cords and		
	Director and Execu	tive Director at exit conference.			power strip use will be conduc	ted	
	2.1.10(1)				by staff.		
	3.1-19(b)				Ovelity Assumers as Blass of		
					Quality Assurance Plans to	40	
					monitor facility performance	το	
					ensure corrections are	laa	
					achieved and deficient pract	ice	
					Any deficiencies and correction	ne	
					will be reported monthly to QA		
					Committee for 6 months. The	u I	
					QAPI Committee will determin	۵	
					the need for continued or	C	
					additional corrective actions to	,	
					maintain compliance.	,	
			- 1		mantani compnance.		I

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