

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  07/31/2015
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NAME OF PROVIDER OR SUPPLIER  CROWN POINT CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000  Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/07/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/31/15 Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000</p> <p>At this PSR survey, Chicagoland Christian Village was found in substantial 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 corridors, in spaces open to the corridors</p>	K 0000	<p>K 000 This Plan ofCorrection is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constituteadmission or agreement by the provider of thetruth of the facts alleged or conclusions set forth in the statement ofdeficiencies. The plan of correction is prepared and/or executedsolely 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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K 0130 SS=B Bldg. 01	<p>and in resident rooms. The facility has a capacity of 144 and had a census of 128 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>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, interview, and observation, the facility failed to install a 1.5 hour door in accordance to LSC 101 8.2.3.2.3.1. Section 8.2.3.2.3.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protective's (1) 2 hour fire barrier -- 1 1/2 hour fire protection rating. This deficient practice could affect 62 residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/31/15 at 10:21 a.m. the fire door in C Hall was still rated for 60 minutes. Based on interview and record review, the</p>	K 0130	<p>REQUEST DESK COMPLIANCE</p> <p>K 130</p> <p>1.What corrective action (s) will be accomplishedfor those residents found to have been affected by the deficient practice.</p> <p>a. The facility will install a fire barrier door with rating that meets LSC101.8.2.3.2.3.1 Section 8.2.3.2.3.1</p> <p>2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken:</p> <p>1.Residents, staff and visitors have the potentialto be affected.</p> <p>2.The corrections being</p>	08/10/2015

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	<p>Maintenance Director provided documentation requesting a quote from a company to replace the door. No other documentation was provided.</p> <p>During the Recertification life safety survey the following was discovered: "Based on interview and record review with the Maintenance Supervisor and Administrator in Training on 07/07/15 during record review between 9:50 a.m. and 11:06 a.m., site plans were reviewed and the Maintenance Supervisor pointed out the facility's fire and smoke barriers. A two hour fire barrier in C Hall was noted. Based on observation with the Maintenance Supervisor at 3:40 p.m., the fire door rating in the C-Hall was rated for 60 minutes. The Maintenance Supervisor acknowledged the aforementioned condition."</p> <p>3.1-19(b)</p>		<p>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. The Maintenance director has secured a bid to replace fire barrier door to meet LSC 101.8.2.3.2.31Section 8.2.3.2.3.1</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>1.The maintenance supervisor/designee is responsible for ongoing compliance.</p> <p>2.Attached is the invoice from Crown interiors for replacement of the named fire door. (attachment #1)</p>		