

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  08/08/2013
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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: 08/08/13</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>K0000This Plan of Correction is the center's credible allegation of compliancePreparation 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 revisions of federal and state law.</p>	
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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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	<p>corridors, in spaces open to the corridors and in resident rooms. The facility has the capacity for 144 and had a census of 135 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 08/13/13.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>			

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure a door to a hazardous area such as a kitchen, in 1 of 10 smoke compartments, would self close and latch into the door frame.</p> <p>Sprinklered hazardous areas are required to be equipped with self closing doors or with doors which close automatically upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, staff and 10 or more residents in the adjacent dining room and lounge.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/08/13 at 1:45 p.m., the self closing kitchen door near the elevators was equipped with a dead</p>	K010029	<p>K 029 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. No visitors, residents or staffs were harmed by this practice b. The deadbolt door latch was repaired immediately to a knob type while a lever Korbin type door lock was ordered 8/19/13. 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: a. Residents, staff and visitors have the potential to be affected. b. The maintenance supervisor will re-check the kitchen door affected to ensure proper closing. c. Doors reviewed to determine if any other doors are affected. No other doors found with dead bolt latches at this time. 3. What measures will be put into place or what systemic</p>	08/23/2013			

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	<p>bolt latch which would not allow the door to latch automatically into the door frame. The maintenance director acknowledged at the time of observation, the door could not latch automatically into the door frame.</p> <p>3.1-19(b)</p>		<p>changes will be made to ensure that the deficient practice does not recur: a. The identified dead bolt latch will be replaced and door placed on preventive maintenance checklist. (See attachment #1, 2 &amp; 3) b. The maintenance supervisor and/or designee will conduct monthly audits to ensure that door is in proper working order, for six months beginning 8/23/13. c. Administrator will conduct random weekly audit to ensure that door is in proper working order for six months. 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. a. The maintenance supervisor or designees are responsible for compliance. b. Monthly audits will be reported to the Compliance Nurse and discussed at the quarterly QA meeting to ensure compliance with this citation.</p>		

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K010051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 fire alarm control panels in an area not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at the location before it could be incapacitated by fire. LSC 9.6.2.10.1 requires smoke alarms shall be in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location. This deficient practice affects all occupants.</p>	K010051	K 051 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. No visitors, residents or staffs were harmed by this practice 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: a. All residents, staff and visitors have the potential to be affected. b. All fire alarm control panels examined for presence of electrical supervised smoke detector. No other fire alarm control panels found without electrical supervised smoke detectors at this time. 3.	08/23/2013

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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 08/08/13 at 3:50 p.m., an adjunct fire alarm control panel (FACP) was located in the entry foyer of the lower level, an area was not continuously occupied. The area was not electrically supervised by a smoke detector. The maintenance director acknowledged at the time of observation, the panel had no smoke detector supervision.</p> <p>3.1-19(b)</p>		<p>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 identified electrical supervised smoke detector replaced 8/15/13 and area placed on preventive maintenance checklist. (See picture and copy of invoice Attachment #4 &amp; 5)</p> <p>b. New electrical supervised smoke detector in place and therefore no further audit required. c. Within one year of installation this smoke detector will be sensitivity tested. 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 will discuss details of the need for installation and future sensitivity testing at the Quality Assurance Committee. b. The committee will ask questions as they feel appropriate.</p>		