STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155637	A. BUILDING -- B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Dates: 03/31/2025 Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000 At this Emergency Preparedness survey, Crown Point Health Campus was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 145 and had a census of 111 at the time of this survey. Quality Review completed on 04/02/25	E 0000		
E 0024 SS=F Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(Policies/Procedures-Volunteers and Staffing Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all residents, staff and visitors. Findings include:	E 0024	Upon identification of the deficiency, the Executive Director and Maintenance Director initiated an immediate review of the facility's Emergency Preparedness Policies. Revisions were made to address the following: Clear procedures for the deployment and supervision of volunteers during emergencies, including documentation and orientation requirements,	04/18/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Maurice	Executive Director	04/14/2025

Any defiencystatement 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING -- B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review and interview with the Executive Director and Maintenance Director at 12:32 p.m. on 03/31/2025, the facility's Emergency Preparedness Policies and Procedures did not address the use of volunteers in an emergency, emergency staffing strategies, or the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. Based on record review at 12:32 p.m. the Executive Director provided a policy that discussed staffing; however, the policy did not include emergency staffing. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.		development of a formal emergency staffing strategy that outlines staff pooling, cross-training, and shift adjustments in disaster scenarios. A defined protocol for integrating State or Federally designated healthcare professionals, including credential verification, communication procedures, and coordination with public health authorities A revised Emergency Preparedness Policy has been submitted and approved internally. **Identification of Other Residents with Potential to Be Affected:** While no residents were directly harmed, all residents had the potential to be affected by the lack of comprehensive planning for staffing and volunteer integration during emergency situations. This was addressed proactively through systemic policy enhancements. **3. Systemic Changes Implemented:** The Emergency Preparedness Policy has been formally updated and will be incorporated into the facility's Emergency Operations Plan All Department Heads received targeted training on the new protocols during the April 11 meeting. Emergency drills will include volunteer and surge staffing scenarios	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155637	A. BUILDING -- B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Facility leadership will establish a protocol to annually review and update the Emergency Preparedness Plan or following any emergency event. **4. Monitoring and Quality Assurance:** The facility's Emergency Preparedness Committee will review all components of the Emergency Plan quarterly. The results of internal audits and staff training compliance will be reported to the QAPI Committee with the quarterly review. Documentation logs for volunteer use and emergency staffing responses will be maintained and reviewed post-drill or real event.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 03/31/2025 Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000 At this Life Safety Code survey Crown Point Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 01 B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors, and in the resident sleeping rooms. The facility has a capacity of 145 and had a census of 111 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 04/02/25			
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm system was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director at 1:17 p.m. on 03/31/2025, the fire control panel indicated the time of 12:15 p.m. and date of 11/25. Based on interview with the Maintenance Director at 1:17 p.m. on 03/31/2025, he acknowledged the time on the fire control panel was incorrect, stating we recently changed to daylight savings time.	K 0345	**1. Corrective Action** Upon surveyor notification of the concern, the Maintenance Director manually updated the fire alarm control panel to reflect the correct time and date. Functionality of the system was confirmed, and there was no impact to resident safety or emergency response capabilities. **2. Identification of Other Residents** Since the fire alarm system services the entire facility, all residents, staff, and visitors could have potentially been affected had an emergency event occurred. The Maintenance Director conducted a comprehensive inspection of the fire alarm system to ensure all	04/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 01 B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		components were operating correctly and no other discrepancies were present. **3. Measures and/or Systemic Changes** The facility Preventive Maintenance Schedule has been updated to include monthly verification of the fire alarm control panel's date and time. The Maintenance Director and staff were Educated on the regulatory requirement to maintain accurate system time as it pertains to NFPA 72 and accurate alarm event logging. **4.How the Facility Will Monitor** The Maintenance Director or designee will conduct monthly audits for six months to verify accuracy of the fire alarm control panel's time and date. Any findings of noncompliance will result in immediate correction and re-education, and will be reported during the facility monthly QAPI meetings to ensure continued compliance.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to	K 0353	**1. Corrective Action** Although no actual harm was noted, all residents and staff were potentially affected by the lack of proper documentation of sprinkler gauge inspections. As an immediate corrective action, the	04/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 01 B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ensure that they are in good condition and that normal water supply pressure is being maintained. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents and staff in the facility. Findings include: Based on record review and interview with the Executive Director and Maintenance Director at 10:35 a.m. on 03/31/2025, monthly sprinkler gauge inspection documentation for was not available for review. Based on record review at 10:35 a.m. the facility provided documentation indicating a monthly inspection of the sprinkler system valves had been completed; however, this documentation did not indicate if a gauge inspection had been completed or the results of the inspection. Based on interview with the Maintenance Director at 10:35 a.m., he stated the TELS program does not allow for him to enter information and only allows to mark the task as completed. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		Maintenance Director performed and documented a full inspection of all sprinkler system gauges on 04/01/2025. All gauges were found to be in good condition with normal water pressure levels. **2. Identification of Other Residents Who Could Be Affected** All residents in the facility could be affected by this deficient practice. A facility-wide review of all water-based fire protection system inspection records was conducted on 04/02/2025 to ensure all required inspections and documentation are current and complete. **3. Measures and/or Systemic Changes to Ensure the Deficient Practice Does Not Recur** The Maintenance Director and Executive Director reviewed NFPA 25 requirements, specifically Section 5.2.4.1 and 4.3.1, to ensure full understanding of proper documentation standards. The facility has updated the inspection protocol to include a specific checklist for **sprinkler gauge inspections**, which includes space to record: Date of inspection Condition of the gauge Water pressure reading Inspector's name and signature The Maintenance Director will conduct monthly audits of the inspection documentation to verify	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 01 B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			completeness and accuracy for the next six months. **4. Monitoring** The Executive Director or designee will review sprinkler system documentation monthly for six months to ensure inspections are completed and documented in accordance with NFPA 25. Results of the audits will be reviewed during monthly QAPI meetings for six months. Any discrepancies will be addressed immediately, and additional training provided if necessary.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. LSC 19.3.6.3.5 states doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. This deficient practice could affect residents, staff and visitors in 1 of 7 smoke compartments. Findings include: Based on observation and interview with the Maintenance Director at 1:39 p.m. on 03/31/2025, resident room I corridor door in the Independence	K 0363	**1. Corrective Action** The corridor door to resident room I was immediately evaluated following the survey. The door hardware and frame were adjusted and repaired to ensure the door closes and latches securely when tested with the required 5 lbf(22 N) of force. The door was tested post-repair and confirmed to be in compliance by the Maintenance Director. **2. Identification of Other Potentially Affected Residents** A facility-wide audit of all resident room corridor doors was conducted to identify any additional doors that may not latch or close properly. Any identified issues were promptly addressed	04/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 01 B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Hall was not able to be closed and latched. At the time of observation, the Maintenance Director attempted to close and latch the door more than three times but was unable to latch the door. Based on interview at 1:39 p.m., the Maintenance Director acknowledged the door would not latch. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		through adjustment or repaired. **3. Systemic Changes to Prevent Recurrence** The Maintenance Department has implemented a monthly preventive maintenance schedule to inspect and test all resident room corridor doors for proper closure and latching function. A door inspection checklist has been created and will be used during these monthly checks. Staff responsible for door maintenance have been **retrained on NFPA 101 Life Safety Code requirements**, specifically regarding corridor door compliance under section 19.3.6.3.5. **4. Monitoring and Quality Assurance** The Maintenance Director or designee will complete and document monthly corridor door inspections monthly for the next 6 months. Results of these inspections will be reviewed by the facility's Quality Assurance and Performance Improvement (QAPI) Committee monthly for to ensure continued compliance.	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review, and interview, the facility failed to ensure annual inspection and testing of 1 of 1 oxygen storage room fire door assemblies was completed. LSC 19.3.2.4 states medical gas storage and administration areas shall be in	K 0761	**Corrective Actions:** An immediate visual inspection of the oxygen storage room fire door assembly has been completed to ensure it meets all fire door	04/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 01 B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	accordance with Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing. 8.7.1.1 states protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means: (1) Enclosing the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.3 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and		requirements as per NFPA 80. The inspection included; Glazing, vision light frames, and glazing beads are intact and securely fastened. Door, frame, hinges, hardware, and threshold are aligned and in working order. The self-closing device is functional and closes the door completely from the full open position. Latching hardware operates properly when the door is closed. No concerns were identified. **Preventive Measures**: An annual inspection of the oxygen storage room fire door assembly has been scheduled moving forward to comply with NFPA 80 requirements. The Maintenance Director will ensure this inspection occurs every year and is documented on the fire door inspection log. A reminder system will be set up to notify staff prior to the inspection due date. The Maintenance Director and relevant staff will receive training on the specific inspection requirements outlined in NFPA 80, focusing on fire door inspection protocols and the importance of maintaining proper documentation. **Deficiency 2: Rolling Fire Door Annual Inspection** **Corrective Actions:** An inspection of the rolling fire door in the kitchen was completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 01 B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review and interview with the Executive Director and Maintenance Director at 11:39 a.m. on 03/31/2025, no documentation of annual inspection of the oxygen storage room fire door assembly was available for review. Based on record review at 11:39 a.m., documentation was provided showing an inspection of smoke compartment doors located in corridors. Based on interview at 11:39 a.m., the Maintenance Director stated an annual inspection was not conducted for the oxygen storage room fire door assembly in the last year. 2.) Based on observation and interview, the facility failed to maintain annual testing of 1 of 1		to ensure compliance with NFPA 80. The inspection confirmed that the door is operational and all components, including the closing mechanism, latching hardware, and frame, are intact and functional. **Preventive Measures**: An annual inspection for the rolling fire door in the kitchen has been scheduled to ensure continued compliance with NFPA 80. The Maintenance Director will oversee the timely completion of this inspection each year. The Maintenance Director and relevant staff have received training on NFPA 80's fire door inspection requirements and the specific inspection protocols for rolling fire doors. The facility maintenance director or designee will complete a monthly audit to verify that all fire door inspections, including those for the oxygen storage room and rolling fire door, are completed on schedule and documented properly. Any discrepancies or missed inspections will be addressed promptly, and corrective actions will be taken. Results of these audits will be reviewed by the QAPI committee to ensure continued compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 01 B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	rolling fire door in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect all residents, staff and visitors in 1 of 7 smoke compartments. Findings include: Based on record review and interview with the Executive Director and Maintenance Director at 11:49 a.m. on 03/31/2025, no documentation for an annual inspection of the rolling fire door was available. Based on interview at 11:49 a.m., the Maintenance Director stated he was not aware of an inspection being completed for the rolling fire door in the facility's kitchen. These findings were reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on observation, record review and interview, the facility failed to ensure all	K 0914	**Corrective Action:** The Maintenance Director	04/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 01 B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	non-hospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Executive Director and Maintenance Director at 12:00 p.m. on 03/31/2025, the facility was not able to provide documentation of annual testing of electrical receptacles. Based on observation with the Maintenance Director during tour of the facility from 12:00 p.m. to 3:45 p.m. on 03/31/2025, non-hospital-grade electrical receptacles were in use in all resident rooms throughout the facility. During record review, the Maintenance Director stated he did not document testing of the electrical receptacles. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		conducted an immediate inspection of all non-hospital-grade electrical receptacles in resident room locations throughout the facility to ensure they are tested for: Physical integrity through visual inspection. Any faulty receptacles been repaired or replaced immediately to meet code requirements. The Maintenance Director and staff responsible for testing have received training on the NFPA 99 code requirements and the necessary steps to properly test non-hospital-grade electrical receptacles. This training will also cover the importance of maintaining accurate documentation of these tests. **Preventative Measures** The Maintenance Director or designee will conduct quarterly inspections of resident room electrical receptacles to confirm that testing is completed and documented. Any discrepancies will be addressed immediately. **Monitoring:** A random audit of documentation will be conducted monthly for the first three months following implementation of this corrective action. The audit will ensure that testing is being completed and documented accurately, and any areas of concern will be corrected promptly. The results of these audits will be reviewed by the QAPI committee monthly for the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 01 B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			first 3 months and quarterly thereafter to ensure continued compliance for a one year period.	
K 0920 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure the use of flexible cords as a substitute for fixed wiring was not used. LSC 9.1.2 requires electrical wiring, and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects all residents, staff and visitors. Findings include: Based on observation and interview with the Maintenance Director on 03/31/2025, 1.) At 9:05 a.m. during the initial entrance to the facility extension cords were observed plugged into red receptacles in the hall and laying across the floor entering into resident rooms. Based on interview at 9:05 a.m. with the Maintenance Director, he stated the facility was running on emergency generator power due to storm damage causing a power outage. The Maintenance Director stated the facility had been running on generator since approximately 3:30 p.m. on 03/30/2025. When asked at 9:05 a.m. about the extension cords, the Maintenance Director stated the facility did not have emergency generator power available in every resident room and the extension cords were being used to supply power to oxygen concentrators and beds. The extension cords were temporarily removed during the time of	K 0920	**Corrective Action:** Cited extension cords and power strips were immediately removed. A visual inspection of the facility has been completed to identify additional use of extension cords, power strips, and multi-plug adapters used as substitutes for fixed wiring will be immediately removed from the facility and replaced with permanent, code-compliant wiring solutions. Any like concerns were immediately remedied. **Preventative Measures:** Staff have undergone training on Life Safety Code requirements, proper use of electrical equipment, and the importance of compliance with NFPA 70 and other applicable codes. The training emphasized the prohibition of using flexible cords or extension cords as a substitute for fixed wiring. **Monitoring:** A weekly inspection of all electrical systems and equipment will be conducted by the Maintenance Director to ensure continued compliance with Life Safety Code regulations. Any use	04/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 01 B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the initial entrance and interview with the Maintenance Director at 9:05 a.m. 2.) At 1:33 p.m. an extension cord was observed laying across the hallway floor entering a resident. At 1:43 p.m. the extension cord was observed plugged into a red receptacle in the hallway and entering resident room "E" on the Independence Hall. Based on observation, the extension cord was providing power to a non-hospital grade power strip that was supplying power to an oxygen concentrator and an air-mattress on a resident bed. Based on interview at 1:33 p.m. the Maintenance Director acknowledged the extension cord and power strip. 3.) At 2:17 p.m. a refrigerator and microwave was observed plugged into a power strip of an unknown rating, in the Director of Nursing Office. Based on interview at 2:17 p.m. the Maintenance Director acknowledged the refrigerator, and microwave was plugged into a power strip that was plugged into an extension cord. 4.) At 2:44 p.m. a refrigerator was observed plugged into a power strip of an unknown rating, in the IP Nursing/Scheduler Office. Based on interview at 2:44 p.m. the Maintenance Director acknowledged the refrigerator was plugged into a power strip. 5.) At 2:48 p.m. an extension cord was observed laying across the hallway floor entering into resident room 132. Based on observation, a multi-plug adapter was plugged into the extension cord and provided power to a bed, an air mattress on the bed, and another extension cord. The second extension cord was providing power to a cell phone charger, a tablet charger, and another personal electronic device. Based on interview at		of extension cords, power strips, or other flexible cords will be immediately addressed and corrected. The results of this audit will be submitted to the QAPI committee on a monthly basis to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 01 B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2:48 p.m. the Maintenance Director acknowledged the multi-plug adapter was plugged into an extension cord that provided power to a bed, an air mattress on the bed, a second extension cord that was providing power to a cell phone charger, a tablet charger, and another personal electronic device. 6.) At 2:51 p.m. a power strip of an unknown rating located under the head of the resident bed, was observed providing power to a nebulizer and a make-up light in resident room 133. Based on interview at 2:44 p.m. the Maintenance Director acknowledged the nebulizer, and a make-up light were plugged into a non-hospital grade power strip. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			