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	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 E 117TH AVE 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. --		E 0000		
	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/11/18 Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000 At this Emergency Preparedness survey, Crown Point Christian Village was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility is certified for 146 beds, and is set up for 144. Eighty-seven beds are dually certified for Medicare and Medicaid. Twenty-six are certified for Medicare only. At the time of the survey, the census was 117. Quality Review completed on 10/16/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:			
E 0024 SS=C Bldg. --		E 0024	1.Information related to the integration of volunteers and or emergency staff has been added to all Emergency Preparedness binders.	11/02/2018
	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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 E 117TH AVE 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
	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 occupants. Findings include: During record review with the Executive Director and Maintenance Supervisor on 10/10/18 at 12:19 p.m., no documentation could be located regarding the use or integration of volunteers or other emergency staffing strategies in the event of an emergency. This includes non-medical volunteers, medically-trained volunteers, and State or Federally designated professionals. During interview at the time of record, the Executive Director acknowledged that a policy regarding volunteers was not yet created.		2.Staff is being educated on this requirement. 3.The Emergency Preparedness Binder will be reviewed for to ensure completeness and accuracy semi-annually in October and April. Any updates or education will be completed at that time. 4.The Maintenance Director or Designee will report any changes at the QAPI Committee in November and May.	
E 0026 SS=C Bldg. --	Based on record review and interview, the facility failed to develop policies and procedures of the role of the facility under a waiver declared by the Secretary of Health and Human Services, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials, as required by 42 CFR 483.73(b)(8). This deficient practice could affect all residents, staff, and visitors. Findings include: During record review with the Executive Director and Maintenance Supervisor on 10/11/18 at 12:24	E 0026	1.Information related to the 1135 waiver including a policy and procedure has been added to all Emergency Preparedness binders. 2.Staff is being educated on this requirement. 3.The Emergency Preparedness Binder will be reviewed for to ensure completeness and accuracy semi-annually in October and April. Any updates or education will be completed at that time. 4.The Maintenance Director or Designee will report any changes at the QAPI Committee in	11/02/2018

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	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 E 117TH AVE 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
	p.m., no documentation of policies and procedures of the role of the facility under a waiver declared by the Secretary of Health and Human Services, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials could be located. Based on interview at the time of record review, the Executive Director and Maintenance Supervisor were unaware of the 1135 waiver, and confirmed that there was no policy in place.		November and May.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/11/18 Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000 At this Life Safety Code survey, Crown Point Christian Village 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 National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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	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	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 E 117TH AVE 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
	sprinklered. The Healthcare Occupancy includes the atrium area of the third floor as it not separated by a two-hour barrier. No residents use the third floor. The facility has a fire alarm system with hard wired smoke detection in the corridors, in spaces open to the corridors and in hard wired single-station detectors in resident rooms. The facility is certified for 146 beds, and is set up for 144. Eighty-seven beds are dually certified for Medicare and Medicaid. Twenty-six are certified for Medicare only. At the time of the survey, the census was 117. 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. Quality Review completed on 10/16/18 - DA			
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.			

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	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 E 117TH AVE 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
	Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to provide a two-hour rated construction of 1 of 2 separation walls between an assisted-living occupancy and health care occupancy. This deficient practice could affect all patients, staff, and visitors of the health care facility. Findings include: During a tour of the facility with the Maintenance Supervisor on 10/11/18 at 3:19 p.m. two 1 inch penetrations were found on the first floor above the ceiling tile in the 2-hour barrier that separated the Health care occupancy from the Assisted-Living occupancy. Specifically, the penetrations were in two stubbed out conduits for telecommunication cabling. Based on interview at the time of observation, the Maintenance Supervisor confirmed the penetrations and agreed with the measurements. 3.1-19(b)	K 0131	1.Cited Smoke Barrier Penetrations were sealed with the required fire rated calk. 2.A complete review of all areas of the building was completed to identify other smoke barrier penetrations. No like circumstances were identified. 3.Smoke Barrier Penetrations have been added to the community safety rounds monthly audit. The audit will be completed by the Maintenance Director or Designee and will include 5 areas of the building where fire doors are located. 4.The results of the aforementioned audit will be reviewed monthly by the QAPI committee for no less than 6 mos.	11/02/2018
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5			

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	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 E 117TH AVE 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 observation, the facility failed to protect 3 of 9 corridors in accordance with LSC Section 19.2.3.4(4). LSC 19.2.3.4(4) states that projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect staff and up to 22 residents in the Haven Unit, and 30 residents in the Grace Point Unit and 19 residents in the Eden-Daniel Unit Findings include: During a tour of the facility with the Maintenance Supervisor on 10/11/18 from 1:30 p.m. to 3:30 p.m. the following conditions were found: a) At 1:47 p.m. a non-wheeled isolation cart was located in the corridor outside of Resident Room 271. b) At 1:54 p.m. a non-wheeled isolation cart was located in the corridor outside of Resident Room H. c) At 2:55 p.m. a non-wheeled isolation cart was located in the corridor outside of Resident Room 148. At the time of observations, the Maintenance Director acknowledged the isolation carts were	K 0232	1.The non- wheeled isolation carts present outside of Room H, 271 and 148 were removed and replaced with wheeled carts. 2.Observations rounds of the building and storage areas were completed no other isolation carts or other carts that may be present in corridor areas were observed. 3.Individuals responsible for ordering said equipment have been educated on the requirement for these carts to be wheeled. They have also been provided with the specific order numbers for wheeled carts. Carts without wheels present in corridors" has been added to the monthly safety rounds audit sheet. These rounds are to be completed by the Maintenance Director or 4.Designee. 5.The results of these audits will be reviewed with the QAPI Committee on a monthly basis for no less than 6 mos.	11/02/2018

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	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 E 117TH AVE 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
	not wheeled. 3.1-19(b)			
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1) Based on record review and interview, the facility failed to maintain 1 of 1 fire pumps in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system	K 0353	1.The annual fire pump test had been scheduled at the time of the citation and took place as scheduled on 10/15/18. The waterflow alarm in the lower level mechanical room was covered. 2.A review of fire pump testing has been completed and no concerns were identified. A review the waterflow alarm testing was completed and no concerns were identified. 3.The Maintenance Director was aware of the requirement. The	11/02/2018

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	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 E 117TH AVE 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
	components and shall be made available to the authority having jurisdiction upon request. Section 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, Table 8.1.1.2 requires that fire pumps are inspected and tested annually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: During record review with the Maintenance Supervisor on 10/11/18 at 11:27 p.m. documentation indicated the last annual fire pump inspection occurred on 08/30/17. During an interview at the time of record review, the Maintenance Supervisor acknowledged the fire pump had not been inspected within the most recent twelve month period. He further stated the service was scheduled to occur on 10/15/18. 3.1-19(b) 2) Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system waterflow alarm in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 Section 5.2.5 states that waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical		annual fire pump test for 2019 has been scheduled for September 10, 2019. A quarterly waterflow alarm test has been scheduled as required for the next 12 mos. The Maintenance Director will be responsible for ensuring the water flow alarm is covered post inspection. 4.The annual fire pump testing will be reviewed annually at the October QAPI meeting to ensure substantial compliance. The quarterly waterflow alarm testing, including any inspection concerns will be reviewed quarterly by the QAPI Committee.	

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	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 E 117TH AVE 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
	damage. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: During a facility tour with the Maintenance Supervisor on 10/11/18 at 2:35 p.m. the sprinkler-system waterflow alarm in the Lower Level mechanical room was found uncovered. Based on interview at the time of observation, the Maintenance Supervisor agreed that the alarm device was not protected. 3.1-19(b)			
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that			

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	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 E 117TH AVE 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
	release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 resident room door of over 50 doors to the corridor were maintained in accordance with LSC Section 19.3.6.3. Section 19.3.6.3.5 states that corridor doors shall be provided with a means for keeping the door closed. Section 19.3.6.3.10 states that doors shall not be held open by devices other than those that release when the door is pushed or pulled. The deficient practice could affect staff and up to 1 resident in resident room 116. Findings include: During a tour of the facility with the Maintenance Supervisor on 10/11/18 at 2:52 p.m. the door to resident room 116 did not latch into the frame after numerous attempts. This was acknowledged by the Maintenance Director at the time of observation, who agreed that the door did not latch into the frame.	K 0363	1.The door to room 116 was immediately repaired and tested to ensure that it positively latched into the frame. 2.All resident room doors have been tested and ensured to positively latch. 3.Staff has been educated on this requirement. “Resident room doors positively latching” has been added to the monthly safety rounds sheet audit tool. 5 resident room doors per corridor will be tested monthly. These rounds are to be completed by the Maintenance Director or Designee. 1.The results of these audits will be reported to the QAPI Committee on a monthly basis for no less than 6 mos.	11/02/2018

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	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 E 117TH AVE 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
	3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8.5. 8.5.6.3 states that where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5. 8.3.5.1 states that penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The fire stop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through	K 0372	1.Cited Smoke Barrier Penetrations were sealed with the required fire rated calk. 2.A complete review of all areas of the building was completed to identify other smoke barrier penetrations. No like circumstances were identified. 3.Smoke Barrier Penetrations have been added to the community safety rounds monthly audit. The audit will be completed by the Maintenance Director or Designee and will include 5 areas of the building where fire doors are located. 4.The results of the aforementioned audit will be reviewed monthly by the QAPI committee for no less than 6 mos.	11/02/2018

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	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 E 117TH AVE 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
	Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops. This deficient practice could affect staff and up to 30 residents in the Smoke Compartments adjacent to the Gracepoint 2 fire wall. Findings include: During a tour of the facility with the Maintenance Supervisor on 10/11/18 at 3:13 p.m. one 1 inch penetration was located above the ceiling tile in the Gracepoint 2 fire wall near resident room 265. This was confirmed by the Maintenance Supervisor who agreed with the measurement. 3.1-19(b)			
K 0753 SS=D Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility	K 0753	1.Candles were removed from resident room 261.	11/02/2018

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	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 E 117TH AVE 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
	failed to ensure 1 of 1 resident room was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect staff and up to 13 resdients in the Gracepoint 1 Unit. Findings include: During a tour of the facility with the Maintenance Supervisor on 10/11/18 at 2:01 p.m. two candles with wicks were located in resident room 261. Based on interview at the time of observation, the Maintenance Supervisor confirmed the presence of candles with wicks. It was acknowledged that this was corrected prior to exit 3.1-19(b)		2.Observation rounds of all resident rooms were completed. No like circumstances were identified. 3.Staff education is being completed on this concern. “Candles with wicks” has been added to the monthly safety round sheet audit tool. This audit will be completed monthly by the Maintenance Director or Designee. 20 rooms throughout the building will be observed for candles. 4.The results of this audit will be reviewed by the QAPI Committee on a monthly basis for no less than 6 mos.	