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	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	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: 04/15/2024 and 04/16/24 Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000 At this Emergency Preparedness survey, Crown Point Christian Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility is certified for 145 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 100. Quality Review completed on 04/22/24	E 0000	The facility kindly requests a desk review.	
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). This visit was in conjunction with the Life Safety Code Preoccupancy Survey that exited on 04/15/24. Survey Date: 04/15/2024 and 04/16/24	K 0000	The facility kindly requests a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Porcaro	Administrator	05/03/2024

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.

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	155637	A. BUILDING 01 B. WING	04/16/2024

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	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 sprinklered. The Healthcare Occupancy includes the atrium area of the second floor as it not separated by a two-hour barrier. No residents use the second floor. The facility has a fire alarm system with hard wired smoke detection in the corridors, in spaces open to the corridors and hard wired single-station detectors in resident rooms. The building is protected by a 150 kW diesel-powered generator which provides emergency power. The facility is certified for 145 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 100. 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 04/22/24			

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	155637	A. BUILDING 01 B. WING	04/16/2024

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 1 soiled utility rooms in Gracepoint 2 Wing were protected as a hazardous area with a self-closing door that would automatically latch into the frame. This deficient	K 0321	**Crown Point Christian Village** **Life Safety Code** **Recertification and Emergency Preparedness Survey** **4.15.24**	05/03/2024

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	practice could affext approximately 20 residents and staff. Findings include: Based on observations the Administrator and the Maintenance Director on 04/15/24 between 1:30 p.m. and 4:00 p.m., the soiled utility (which contained barrels of trash and soiled linen) next to resident room 265 was equipped with self-closing door, but the door did not latch into the frame after testing three times. Based on interview at the time of observation, the Maintenance Director agreed the soiled utility room door was not latching into the frame when tested and would get it adjusted. The door was able to be fixed and latched by the end of the survey. This finding was reviewed with the Maintenance Director, Administrator and Executive Director during the exit conference. 3.1-19(b)		**K 321 Hazardous Areas-Enclosure** Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The soiled utility room on Grace Point 2 was equipped with a self-closing door, but the door did not latch. The door was fixed and latched by the end of the survey. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** The deficient practice has the potential to affect all staff, residents, and visitors. **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** Maintenance was educated on ensure all the self-latching doors will latch into the frame when	

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			closed. A monthly random audit of various areas of the facility will be completed for 6 months to ensure compliance. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? Copy of audit will be reviewed at safety committee meeting for a duration of 6 months. All other deficient practices will be immediately corrected upon occurrence. Maintenance Director/designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. **Date of Completion: 5.3.24**	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of			

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	interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation, records review, and interview, the facility failed to ensure materials used as an interior finish on corridor walls on 2 of 2 floors met the flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 101 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect approximately 40 residents and staff. Findings include: Based on observation with the Maintenance Director between 1:30 p.m. and 4:00 p.m. on 04/15/24, carpet wall covering was noted throughout parts of the first and second floor corridor walls. During record review between 09:19 a.m. and 1:30 p.m., no documentation of interior	K 0331	**Crown Point Christian Village** **Life Safety Code** **Recertification and Emergency Preparedness Survey** **4.15.24** **K 331 Interior Wall and Ceiling Finish** Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The facility has obtained the documentation of the flame spread rating of carpet wall coverings throughout parts of the first and second floor corridor walls. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** The deficient practice has the potential to affect all staff, residents, and visitors only if the	05/03/2024

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	finish test methods for the carpet could be located. Based on interview at the time of observation, the Maintenance Director stated that the wall coverings have been on for a period of time and was unsure if the carpet had a flame spread rating for it. This finding was reviewed with the Maintenance Director, Administrator and Executive Director during the exit conference. 3.1-19(b)		laminate assembly was not fire rated and were combustible. **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** The maintenance department was educated on having proper documentation of the flame spread rating. The property manager will audit flame spread binder to ensure compliance. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? Copy of audit will be reviewed at safety committee meeting for a duration of 6 months. All other deficient practices will be immediately corrected upon occurrence. Maintenance Director/designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.	

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			Date of Completion: 5.3.24	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants. Findings include:	K 0345	**Crown Point Christian Village** **Life Safety Code Recertification and Emergency Preparedness Survey** **4.15.24** **K 345 Fire Alarm System-Testing and Maintenance** Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**	05/03/2024

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	Based on record review with the Maintenance Director on 04/15/24 between 09:19 a.m. and 1:30 p.m., the fire alarm annual functional testing documentation dated 06/1/23 indicated that sensitivity testing had been conducted for all smoke detectors. Upon further investigation, four smoke detectors were left out of the sensitivity testing. Two smoke detectors in the main dining room and two smoke detectors in the main chapel were not tested for sensitivity. No further documentation could be found indicating that those smoke detectors have had sensitivity testing within the past two years. Based on interview at the time of record review, the Maintenance Director acknowledged the missing testing for the aforementioned smoke detectors and agreed they were missing inspections. This finding was reviewed with the Maintenance Director, Administrator and Executive Director at exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances		Four smoke detectors, 2 in the main dining room and two smoke detectors in the main chapel were not tested for sensitivity. An appointment for sensitivity testing for the 4 smoke detectors has been scheduled with Safe Care for 5/10/24. The facility was missing documentation for no visual inspection of other appliances or device six months after the annual functional testing was completed. The 2nd 6 month inspection has been completed. The hardwired smoke detector located in resident room 267 was unsecured and hanging from the ceiling. The smoke detector is now secured to the ceiling. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** The deficient practice has the potential to affect all staff, residents, and visitors. **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?**	

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	e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: During records review with the Maintenance Director on 04/15/24 between 09:19 a.m. and 1:30 p.m., documentation of smoke detector inspections was found and conducted on a monthly basis. Also, the fire alarm functional testing was completed on 06/01/23. No visual inspection of other appliances or devices could be located during the survey 6 months after the annual functional testing. Based on interview at the time of record review, the Maintenance Director confirmed that the fire alarm system was only conducted once. This finding was reviewed with the Maintenance Director, Administrator and Executive Director at the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 10.4.2 requires that devices and appliances shall be located and mounted so that accidental operation or failure is not caused by vibration or jarring. This deficiency could affect approximately 20 residents and staff. Findings include:		The maintenance department was educated to ensure that all smoke detectors are tested for sensitivity. The maintenance department was educated to ensure that visual inspection semi-annually of the fire alarm system. The maintenance department was educated to ensure that all smoke detectors are secured to the ceiling. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? Copy of audit will be reviewed at safety committee meeting for a duration of 6 months. All other deficient practices will be immediately corrected upon occurrence. Maintenance Director/designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. **Date of Completion: 5.3.24**	

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	Based on record review with the Maintenance Director on 04/15/24 between 1:30 p.m. and 4:00 p.m., the hardwired smoke detector located in resident room 267 was unsecured and hanging from the ceiling. Based on interview at the time of observation, the Maintenance Director confirmed the smoke detector was unsecured and would have to be addressed. Findings were reviewed with the Maintenance Director, Administrator and Executive Director at exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility	K 0351	**Crown Point Christian Village**	05/03/2024

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	failed to maintain the ceiling construction in 1 of 6 smoke compartments in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director 04/15/24 between 2:18 p.m. and 4:00 p.m., a sprinkler head located on the ceiling in the corridor next to resident room 259 had its escutcheon plate missing which left annular space between the sprinkler head and the ceiling. Based on interview at the time of observation, the Maintenance Director confirmed that the escutcheon plate was missing. Findings were discussed with the Maintenance Director, Administrator and Executive Director at exit conference. 3.1-19(b)		**Life Safety Code Recertification and Emergency Preparedness Survey 4.15.24** **K 351 Sprinkler System-Installation** Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The facility has replaced the missing escutcheon plate around the sprinkler head and ceiling by resident room 259. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** The deficient practice has the potential to affect all staff and residents in the facility. **What measures will the facility take or what systems will the facility alter to ensure that the**	

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			problem will be corrected and will not recur? The Maintenance Department was educated to ensure that all sprinkler heads have the escutcheon plate in place. A one time audit of the sprinklers heads all have the escutcheon plates to ensure compliance in other areas. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? Copy of audits will be reviewed at safety committee meeting for a duration of 6 months. All other deficient practices will be immediately corrected upon occurrence. Maintenance Director/designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. **Date of Completion: 5.3.24**	
K 0353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 01	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 automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect approximately all residents, staff, and visitors in the facility.	K 0353	**Crown Point Christian Village** **Life Safety Code** **Recertification and Emergency Preparedness Survey** **4.15.24** **K 353 Sprinkler System-Maintenance and Testing** Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient**	05/03/2024

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	Findings include: Based on records review of the annual sprinkler inspection documentation "Sprinkler Inspection Annual Inspection" dated 05/17/23 with Maintenance Director on 04/15/24 between 09:19 a.m. and 1:30 p.m., under the deficiencies section "Deficiency Recap" on page six of the report; numerous sections indicate that the hydraulic nameplates and hydraulic design information sign were not located at the sprinkler system risers. During record review, a service report provided dated 06/11/23 indicated other deficiencies found during that annual inspection had been repaired, however it did not include the repairs/fixing of the hydraulic nameplates and information signs for the sprinkler systems. Based on interview at the time of record review, the Maintenance Director stated that he would have to get in contact with the sprinkler inspection company to see if those deficiencies had been repaired. No other documentation was found during the survey to indicate the repairs had been made. Findings were discussed with the Maintenance Director, Administrator and Executive Director at exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and		**practice?** The annual inspection report did not include the repairs/ fixing of the hydraulic nameplates and information signs for the sprinkler systems. The facility has contacted Hillfire and confirmed that those deficiencies have been repaired. The facility did not document pressures or record if they had passed or failed inspections during the dry sprinkler gauge check. The facility has completed documentation of the dry sprinkler gauge check that includes pressures and/or recorded if they had passed/failed inspections. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** The deficient practice has the potential to affect all staff, residents, and visitors in the facility. **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** The maintenance department was educated on required inspections and how to document	

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	testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly, or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect approximately all occupants. Findings include: Based on records review with the Maintenance Director on 04/15/24 between 09:19 a.m. and 1:30 p.m., documentation titled "Fire Sprinkler System: Dry Sprinkler Gauge Check" was provided during the survey; however the documentation did not contain pressures of the gauges nor if they had passed/failed visual inspections. Based on interview at the time of record review, the Maintenance Director stated that pressures and gauges are visually inspected, however they did not document pressures or recorded if they had passed/failed inspections. Findings were discussed with the Maintenance Director, Administrator and Executive Director at exit conference. 3.1-19(b)		appropriately for the inspections. A monthly audit will be performed for 6 months of all required inspections to ensure compliance. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? Copy of audit will be reviewed at safety committee meeting for a duration of 6 months. All other deficient practices will be immediately corrected upon occurrence. Maintenance Director/designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. **Date of Completion: 5.3.24**	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.			

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	18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire damper systems in the facility were inspected and provided necessary maintenance after the first year after instillation and at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect approximately all residents and staff. Findings include: Based on observation with the Maintenance Director on 04/16/24 between 08:39 a.m. and 9:19 a.m., within the smoke barrier next to room 123 had a fire damper above the drop ceiling. During record review on 04/15/24 between 09:19 a.m. and	K 0521	**Crown Point Christian Village Life Safety Code and Emergency Preparedness Survey 4.15.24** **K 521 HVAC** Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation. **What corrective action will be accomplished for those areas found to have been affected by the deficient practice?** The facility was missing the fire/smoke damper inspections. The facility has a scheduled inspection date for the fire and smoke dampers on 5/15/24 with Premistar. **How will the facility identify other areas having the potential to be affected by the same deficient practice?** This deficient practice has a potential to affect all residents, staff and visitors in the facility.	05/03/2024

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	1:30 p.m., no fire/smoke damper inspections were found during the survey. Based on interview at the time of observation and record review, the Maintenance Director confirmed that there are fire and smoke dampers within the facility, however he was unsure how many the facility had. He further clarified that they are working with an external contractor on getting inspections done at a later date. Findings were reviewed with the Maintenance Director, Executive Director and Administrator at exit conference. 3.1-19(b)		What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur? The maintenance staff was educated to ensure the fire/ smoke dampers inspections comply and shall be installed in accordance with the manufacturer's specifications. **How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?** Administrator/ Maintenance Supervisor will review monthly audits x 6 months to ensure this deficient practice does not recur. Maintenance Director/designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. **Completion Date: 5.3.24**	
K 0712 SS=F	NFPA 101 Fire Drills			

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Bldg. 01	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 3 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 could affect approximately all staff and residents. Findings include: Based on records review with the Maintenance Director on 04/15/24 between 09:19 a.m. and 1:30 p.m., the following shifts were missing documentation of a completed fire drill: a) A third shift drill in the first quarter of 2024 b) Two first shift drills for third and fourth quarter of 2023 Furthermore, documentation used for fire drills titled "Fire Drills, Perform a fire drill" did not list all staff involved nor which situation was used to simulate the fire. Multiple fire drills within 2023 listed only maintenance staff participating in drills. Based on interview at the time of record review, the Maintenance Director stated that multiple staff are involved, however the process for having staff	K 0712	**Crown Point Christian Village** **Life Safety Code and Emergency Preparedness Survey** **4.15.24** **K 712 Fire Drills** Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation. **What corrective action will be accomplished for those areas found to have been affected by the deficient practice?** The facility will continue to have fire drills once per quarter on each shift. However, drills will be conducted at varying times during the shift, and all staff involved will	05/03/2024

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	sign for all fire drills had started this year. Findings were discussed with the Maintenance Director, Executive Director and Administrator at exit conference. 3.1-19(b) 3.1-51(c)		sign for all fired drills. **How will the facility identify other areas having the potential to be affected by the same deficient practice?** This deficient practice has a potential to affect all residents, staff and visitors in the facility. What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur? The maintenance staff was educated on fire drills being conducted at various times during the shift. An audit of all the fire drills will be reviewed for 6 month period to ensure that drills are conducted on different shifts and varying times and that all staff that are involved in the drills are signing documentation. **How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?** Administrator/ Maintenance Supervisor will review monthly audits x 6 months to ensure this deficient practice does not recur. Maintenance Director/designee will present a summary of audits	

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			to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. **Completion Date: 5.3.24**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the			

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	components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to exercise 1 of 2 emergency generators for 12 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect approximately all occupants. Findings include:	K 0918	**Crown Point Christian Village** **Life Safety Code and Emergency Preparedness Survey** **4.15.24** **K918 Electrical Systems-Essential Electric Systems** Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation. **What corrective action will be accomplished for those areas found to have been affected by the deficient practice?** The facility failed to provide completed documentation for the load information to show the actual load percentage for the diesel-powered generator for the second emergency generator, and	05/03/2024

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	Based on review of generator load testing documentation titled "Generator Exercise - under load #2) with the Maintenance Director from 09:19 a.m. to 1:30 p.m. on 04/15/24, the load information to show the actual load percentage for the diesel powered generator was not documented for the second emergency generator, used for the HVAC system. Generator load testing documentation for the first generator was complete and had listed all required information. Based on interview at the time of record review, the Maintenance Director confirmed that the documentation for the second generator was incomplete and was unsure why it was not documented. Furthermore, due to the generator documentation for load percentage not recorded, no load bank test documentation from the past year was found during the survey. Based on interview at the time of record review, the Maintenance Director was not able to confirm if the generator missing the load percentage ran over 30% load each month. This finding was reviewed with the Maintenance Director, Administrator and Executive Director at the exit conference. 3.1-19(b)		no load bank test documentation from the past year. Genset appointment has been set for 5/9/2024 to complete the load bank test and fuel test for both the old and new generators. **How will the facility identify other areas having the potential to be affected by the same deficient practice?** This deficient practice has potential to affect all residents. What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur? The Maintenance department was in-serviced to ensure that the generator load testing will be completed as required. Genset appointment has been set for 5/9/2024 to complete the load bank test and fuel test for both the old and new generators. **How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?** Maintenance Supervisor/designee will conduct monthly audits to ensure that the required generator	

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			load bank testing is completed. Maintenance Director/designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. **Completion Date: 5.3.24**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon			

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	completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects approximately four residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 04/16/24 between 1:30 p.m. and 4:00 p.m. as well as 04/16/24 between 08:39 a.m. and 09:19 a.m., within resident rooms 267 and 262 had two power strips within three feet of the patient bed. The power strip in resident room 267 was used for an oxygen concentrator and miscellaneous non-medical electrical equipment. The power strip was determined to not have a UL rating of 1363A or 6060-1. Furthermore, the power strip in resident room 262 was used to power a CPAP which was not determined to have the same UL rating. Based on interview at the time of observation, the Maintenance Director acknowledged the power strips were not medical grade and intermingled with items for personal use\. The findings were reviewed with the Maintenance Director, Administrator and Executive Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw.	K 0920	**Crown Point Christian Village** **Life Safety Code and Emergency Preparedness Survey** **4.15.24** **K 920 Electrical Equipment-Power Cords and Extensions** Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation. **What corrective action will be accomplished for those areas found to have been affected by the deficient practice?** The power strips in rooms 267, 262, and power strip used for the refrigerator and microwave on Gracepoint 2's nursing manager's office were removed. Administrator contacted supplier and requested new hospital grade power strip designated for patient care areas. **How will the facility identify other areas having the potential to be affected by the same deficient practice?**	05/03/2024

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	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 2 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 04/15/24 between 1:30 p.m. and 4:00 p.m., a refrigerator (high power draw equipment) and microwave (high power draw equipment) were plugged into and supplied power by a power strip in the Gracepoint 2 Nursing Manager's office. Based on interview at the time of observation, the Maintenance Director acknowledged the misused power strip. Findings were reviewed with the Maintenance Director, Administrator and Executive Director at exit conference. 3.1-19(b)		This deficient practice has a potential to affect all residents. Maintenance staff conducted rounds in the entire facility to ensure that the deficiency in contain to this area. What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur? The Maintenance Director and/or designee will review and in-service staff on using only power strips of hospital grade and approved for use in patient care areas. **How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?** Maintenance Supervisor/designee will conduct monthly audits in relation to fire barrier power strips and inspect all new equipment brought into the facility for hospital grade power strips that meet the criteria of patient care vicinity Maintenance Director/designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further	

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			monitoring should continue and for what time period. **Completion Date: 5.3.24**	