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 _____	R **07/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWN POINT CHRISTIAN VILLAGE	**6685 EAST 117TH AVENUE** **CROWN POINT, IN 46307**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A 2nd Post Survey Revisit (PSR) for the 1st PSR conducted on 06/06/24 for the Life Safety Code Recertification and State Licensure Survey that exited on 04/16/24 was conducted by the Indiana Department of Health in accordance with 42 CFR Subpart 483.90(a). Survey Date: 07/08/2024 Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000 At this Life Safety Code PSR, Crown Point Christian Village was found 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	{K 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{K 000}	Continued From page 1 are dually certified for Medicare and Medicaid. Twenty-six are certified for Medicare only. At the time of the survey, the census was 99. 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 07/10/24	{K 000}		