

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155734	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THORNTON TERRACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 188 THORNTON RD HANOVER, IN 47243
--	---

(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
S0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 10/31/12</p> <p>Facility Number: 004075 Provider Number: 155734 AIM Number: 200491220</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Thornton Terrace Health Campus was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors with hard wired and battery powered smoke detectors in the 29 resident sleeping rooms. The healthcare portion of the facility has a capacity of 55 and had a census of 47 at the time of this visit.</p> <p>The facility was not in compliance with state law in regard to sprinkler coverage and in compliance with state law in regard to smoke detector coverage.</p>	S0000	Submission of this plan of Correction is not an admission of Thorntont Terrace Health Campus that the deficiency alleged in the survey are accurate or depict the quality of services provided. This plan of correction is submitted timely in accordance with state and Federal regulatory guidelinesThis plan of correction is inteded to serve as the health facility's credible allegation of compliance with State and Federal regulatory requirements	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155734	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THORNTON TERRACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 188 THORNTON RD HANOVER, IN 47243
--	---

(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
	<p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except the 200 Hall nurses' storage closet and one detached eight foot by twelve foot metal storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/07/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155734	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROVIDER OR SUPPLIER THORNTON TERRACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 188 THORNTON RD HANOVER, IN 47243		
(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	
S9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following: (1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012. (2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012. (3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 3 storage rooms on 200 Hall were provided with complete automatic sprinkler system coverage. This deficient practice could affect 26 residents in the facility who reside on the 200 Hall.</p> <p>Findings include:</p> <p>Based on observation on 10/31/12 at 1:00 p.m. with the director of plant operations, the 200 Hall nurses' storage room which measured two foot by four foot was not provided with sprinkler coverage. This was verified by the director of plant operations at the time of observation.</p>	S9999	<p>Corrective Action: The Director of Plant operations contacted Landmark Sprinkler Inc. and a work order was obtained for a sprinkler to be installed in the closet that was lacking the sprinkler. This work is scheduled to be done the week of 11/26/12-11/30/12. A smoke detector was also installed in this closet on 11/1/12 by the Director of Plant operations. Identify Others: No other areas were found to be without the newly required fire prevention regulation systems. Measures Taken to Prevent: Director of Plant Operations ensured that no other areas in the building were without required with out the newly required fire prevention regulation systems. Monitoring: On 11/19/12 the local fire department conducted the facility's annual fire safety inspection and inservicing with no additional findings.</p>	11/30/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155734	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER THORNTON TERRACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 188 THORNTON RD HANOVER, IN 47243
--	---

(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
	3.1-19(ff)			