PRINTED: 04/03/2025

							MB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155830	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/10/2025	
	NAME OF PROVIDER OR SUPPLIER HARRISON'S CROSSING HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION 0000		STREET ADDRESS, CITY, STATE, ZIP COD 395 8TH AVENUE TERRE HAUTE, IN 47804				
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	: IATE	(X5) COMPLETION DATE
Bldg K 0000	conducted by the In accordance with 42 Survey Date: 03/10 Facility Number: 03/10 Provider Number: AIM Number: 201 At this Emergency Harrison's Crossing compliance with E Requirements for Matternation Participating Provides 3.73 The facility has a chad a census of 50	ndiana Department of Health in 2 CFR 483.73. 2 CFR 483.73. 2 25 2 25 2 25 2 25 2 26 2 290670 Preparedness survey, g Health Campus was found in mergency Preparedness Medicare and Medicaid	E 00	000	The submission of this plan of correction does not indicate admission by Harrison's Cro Health Campus that the finding and allegations contained he are accurate, true represents of the quality of care provide the living environment provide the residents of Harrison's Crossing Health Campus. The facility recognizes its obligating provide legally and medically necessary care and services residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with a state and federal requirement governing the management of acility. It is thus submitted a matter of statute only. The firespectfully requests from the department a desk review for substantial compliance. Corrections to be completed 4/4/2025	an ssing ings erein ation d, and ded to the ton to to its d all atts of this as a acility e r	
DI-I 04							
Bldg. 01	Licensure Survey	e Recertification and State was conducted by the Indiana alth in accordance with 42 CFR	K 0	000	The submission of this plan of correction does not indicate admission by Harrison's Cro Health Campus that the findi	an ssing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Survey Date: 03/10/25

TITLE

and allegations contained herein

are accurate, true representation of the quality of care provided, and

(X6) DATE

Sean Medsker **Executive Director** 03/28/2025

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.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155830	B. WI	NG	<u> </u>	03/10/	/2025
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					H AVENUE		
HARRIS	ON'S CROSSING I	HEALTH CAMPUS		TERRE	HAUTE, IN 47804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Facility Number: 0	013335			the living environment provide	d to	
	Provider Number:	155830			the residents of Harrison's		
	AIM Number: 201	1290670			Crossing Health Campus. The	Э	
					facility recognizes its obligation		
	At this Life Safety	Code survey, Harrison's			provide legally and medically		
		ampus was found not in			necessary care and services t	o its	
	_	equirements for Participation in			residents in an economic and		
	-	Subpart 483.90(a), Life Safety			efficient manner. The facility		
	· ·	2012 edition of the National Fire			hereby maintains it is in		
		tion (NFPA) 101, Life Safety			substantial compliance with al	I	
		ter 19, Existing Health Care			state and federal requirements		
	Occupancies and 410 IAC 16.2.				governing the management of		
	o companiones and .	10 1110 1012			facility. It is thus submitted as		
	This facility was located on the first floor of a two story building determined to be of Type V (111)				matter of statute only. The fac		
					respectfully requests from the	J Ly	
		as fully sprinklered. The			department a desk review for		
		larm system with hard wired			substantial compliance.		
		the corridors, spaces open to			Corrections to be completed b	V	
		all resident rooms. The entire			4/4/2025	У	
		cility, including the Legacy			17 172020		
		ing unit was surveyed due to					
		r fire-rated separation. The					
		city of 72 certified beds and had					
		ne time of this survey.					
		ie dille er dille eur veg v					
	All areas where res	sidents have customary access					
		nd all areas providing facility					
		iklered, except a detached					
	-	e used for the storage of					
	maintenance equip						
	mamtenance equip						
	Ouality Review co	mpleted on 03/14/25					
		p					
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	g 2						
	Based on observati	ion and interview, the facility	K 02	222	1 Corrective Action for th	е	04/04/2025
		e means of egress through 1 of	1.02		resident(s) affected by the	-	0 1/0 1/2023
		ocks was readily accessible for			alleged deficient practice:		
		and visitors. LSC 7.2.1.6.1.1			This deficient practice could ha	ave	
1	,		I				l

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155830		JILDING	onstruction 01	(X3) DATE COMPL 03/10/	ETED
	PROVIDER OR SUPPLIEF			395 8TI	ADDRESS, CITY, STATE, ZIP COD H AVENUE HAUTE, IN 47804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	approved, listed, de permitted to be inst serving low and ord buildings protected	cking Systems allows layed-egress locks shall be alled on door assemblies linary hazard contents in throughout by an approved,			affected 5 Residents and staff the Therapy gym.		
	installed in accorda approved, supervise installed in accorda where permitted in	ed automatic fire detection system in accordance with Section 9.6, or an d, supervised automatic sprinkler system in accordance with Section 9.7, and ermitted in Chapters 11 through 43, l:			2 Corrective Actions take for those resident(s) having potential to be affected by the alleged deficient practice:	the e	
	egress upon activate (a) Approved, super system installed in (b) Not more than of	shall unlock in the direction of ion of one of the following: rvised automatic sprinkler accordance with Section 9.7 one heat detector of an ed automatic fire detections			No Residents, staff or visitors were identified or reported any findings suggestive of having affected by the deficient practi	/ been	
	system in accordand (c) Not more than the approved, supervised system in accordand (2) The door leaves	ce with section 9.6 wo smoke detectors of an ed automatic fire detection			3 Corrective Actions including Measures/Systemi changes put in place to assuthe alleged deficient practice does not reoccur:	ire	
	locking mechanism (3) An irreversible the direction of egre seconds where appringirisdiction, upon a	process shall release the lock in less within 15 seconds, or 30 leaved by the authority having pplication of a force to the lired in 7.2.1.5.10 under all of			The Director of Plant Operation has contacted the vendor to real the audible signal on the Ther Room egress door.	epair	
	(a) The force s 15 lbf (67 N). (b) The force s continuously applie (c) The initiation of activate an audible door opening. (d) Once the door lo application of force	shall not be required to exceed shall not be required to be d for more than 3 seconds. The release process shall signal in the vicinity of the bock has been released by the to the releasing device, y manual means only.			4 Corrective Actions tha will be monitored to ensure to alleged will not re occur: The Director of Plant Operation and/or Designee developed a weekly egress door inspection audit. The Director of Plant Operations and/or Designee we perform the observation audits.	n ons vill	

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	lì í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPL	
		155830	B. W	ING		03/10/	2025
NAME OF P	PROVIDER OR SUPPLIER	ł			ADDRESS, CITY, STATE, ZIP COD		
					HAVENUE		
ПАККІЗ	ON'S CROSSING H	IEAL I II CAIVIPUS		IEKKE	HAUTE, IN 47804		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		e, durable sign in letters not		TAG	three times a week, for three		DATE
		m) high and at least 1/8 in.			months. Findings will be revie	hau	
		vidth on a contrasting			during the quarterly QA	weu	
		ds as follows shall be located			Committee in order to determi	ne	
		acent to the release device in			the frequency for ongoing		
	the direction of egre				monitoring. Findings suggestive	e of	
	"PUSH UNTIL AL				100% compliance may result i		
		PENED IN 15 SECONDS".			cessation of the monitoring pla	an	
	- · · · -	of the doors equipped with			based on review.		
		s shall be provided with					
	emergency lighting in accordance with 7.9. This deficient practice could affect five residents						
	·						
	and staff in the Physical Therapy. Findings include:						
	Based on observation	ons made on 03/10/25 with the					
	Executive Director,	Facilities Management					
		or of Plant Operations during a					
		at 1:55 p.m., the physical					
		as provided with a delayed					
		proper signage indicating the					
		d in 15 seconds by pushing					
		the delayed egress was tested,					
		dible signal in the vicinity of he irreversible process to					
		work properly. Based on					
		e of observation, the Executive					
		an audible signal was not					
		nyed egress was initiated at the					
	exit door in therapy	· ·					
	_	scussed with the Executive					
		Management Support and					
	Director of Plant Op	perations at the exit conference.					
	3.1-19(b)						
K 0225	NFPA 101						
SS=E	Stairways and Sm	okeproof Enclosures					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		ONSTRUCTION (X3) DATE SURVEY O1 COMPLETED 03/10/2025				
	PROVIDER OR SUPPLIER		<u> </u>	395 8TH	ADDRESS, CITY, STATE, ZIP COD H AVENUE HAUTE, IN 47804	
(X4) ID PREFIX TAG Bldg. 01	(EACH DEFICIEN REGULATORY OR Based on observation failed to ensure item	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION on and interview, the facility as stored in 1 of 3 interior fire	K 0	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 1 Corrective Action for th resident(s) affected by the	DATE
	LSC 7.2.2.5.3.1 state enclosure shall not be has the potential to deficient practice co	ould not interfere with egress. es open space within the exit be used for any purpose that interfere with egress. This ould affect second floor ents, staff and visitors using well.			alleged deficient practice: This deficient practice could had affected second floor AL Residents and staff using the center stairwell.	ave
	tour of the facility w Facilities Managem Plant Operations on center exit stairwell	ons and interview during a with the Executive Director, ent Support and Director of 03/10/25 at 2:20 p.m., the was marked as a facility exit. A and 10 decorative cushions in the exit stairwell.			2 Corrective Actions take for those resident(s) having a potential to be affected by the alleged deficient practice: No Residents, staff or visitors were identified or reported any findings suggestive of having I affected by the deficient practice.	the e / been
	Director and Director time of observation conference with the	nfirmed by the Executive or of Plant Operations at the and again at the exit Executive Director, Facilities ort and Director of Plant			3 Corrective Actions including Measures/Systemic changes put in place to ensure the alleged deficient practice does not recur: The Executive Director immediately removed the table and cushions. ED and DPO checked all other stairwells to ensure no other items were stain exit stairwells.	es ored
					4 Corrective Actions that will be monitored to ensure t	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155830	l í	JILDING ING	onstruction 01	(X3) DATE COMPI 03/10	LETED
	PROVIDER OR SUPPLIE ON'S CROSSING I			395 8TI	ADDRESS, CITY, STATE, ZIP COD H AVENUE E HAUTE, IN 47804		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Light		K 0.	291	alleged will not re occur: The Director of Plant Operation and/or Designee developed a weekly exit stairwell audit. The Director of Plant Operations at Designee will perform the observation audits three times week, for three months. Finding will be reviewed during the quarterly QA Committee in onto determine the frequency for ongoing monitoring. Findings suggestive of 100% compliant may result in cessation of the monitoring plan based on reviewed.	ne and/or s a ngs der r	04/04/2025
	failed to ensure all lights were maintain LSC 7.9.2.6 states lights shall use onlibatteries provided maintaining them in Batteries used in suapproved for their with NFPA 70 Nat states the emergence either continuously capable of repeated	battery powered emergency ned in accordance with LSC 7.9. battery operated emergency y reliable types of rechargeable with suitable facilities for n properly charged condition. ach lights or units shall be intended use and shall comply ional Electric Code. LSC 7.9.2.7 ey lighting system shall be in operation or shall be I automatic operation without n. This deficient practice could	K 0.	291	Corrective Action for the resident(s) affected by the alleged deficient practice: This deficient practice could be affected staff. Corrective Actions take for those resident(s) having potential to be affected by the alleged deficient practice: No Residents, staff or visitors.	have en the ne	04/04/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/10/2025 155830 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 395 8TH AVENUE HARRISON'S CROSSING HEALTH CAMPUS TERRE HAUTE, IN 47804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Findings include: were identified or reported any findings suggestive of having been Based on observation with the Director of Plant affected by the deficient practice. Operations, Executive Director and Facilities Management Support at 1:40 p.m. on 03/10/25, the battery operated emergency light inside the generator housing failed to function when its **Corrective Actions** respective test button was pushed five times. including Measures/Systemic Based on interview at the time of observation, the changes put in place to ensure Executive Director confirmed the battery operated the alleged deficient practice light failed to function when its respective test does not recur: button was pushed. This finding was reviewed with the Executive The Director of Plant Operations Director, Facilities Management Support and replaced the battery – operated Director of Plant Operations at the exit conference. light and battery that was located on the inside of the generator 3.1-19(b) housing. The Director of Plant Operations was educated by the Executive Director on Emergency Lighting, Emergency Lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 **Corrective Actions that** will be monitored to ensure the alleged will not re occur: The Director of Plant Operations and/or Designee developed a weekly Emergency Lighting audit. The Director of Plant Operations and/or Designee will perform the observation audits three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155830	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/10/2025	
	PROVIDER OR SUPPLIES		395 8T	ADDRESS, CITY, STATE, ZIP COD TH AVENUE E HAUTE, IN 47804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliant may result in cessation of the monitoring plan based on revi	ce	
K 0311 SS=F Bldg. 01	failed to ensure 1 of proper requirement fire resistance in a accordance with LS new fire protection in accordance with 8.3.4.2, and such maffixed. 8.3.3.6 Gla other than in existin wired glass and other shall be of a design the conditions of ac ANSI/UL 9. Fire p door assemblies, of door assemblies, of door assemblies, sheen tested to meet of NFPA252, ANS	on and interview, the facility of 1 window and frame met the se for window glazing and frame evertical open space in SC 8.3.3. Section 8.3.3.12 states rated glazing shall be marked Table 8.3.3.12 and Table marking shall be permanently marking in fire window assemblies, ong fire window installations of other fire-rated glazing material, of that has been tested to meet exceptance of NFPA 257or rotection-rated glazing in fire other than in existing fire-rated mall be of a design that has the conditions of acceptance I/UL 10B, or 10C. This deficient et all residents, staff and	K 0311	1 Corrective Action for the resident(s) affected by the alleged deficient practice: This deficient practice could haffected all Residents, Staff and Visitors. 2 Corrective Actions take for those resident(s) having potential to be affected by the alleged deficient practice: No Residents, staff or visitors were identified or reported any findings suggestive of having affected by the deficient practice.	en the ee	
	Executive Director Support and Direct	on and interview with the , Facilities Management or of Plant Operations on our of the facility between 12:51		3 Corrective Actions including Measures/Systemi changes put in place to ensuthe alleged deficient practice	ıre	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155830	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/10/2025
	PROVIDER OR SUPPLIER ON'S CROSSING H		395 8T	ADDRESS, CITY, STATE, ZIP COD TH AVENUE E HAUTE, IN 47804	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
K 0321	window in the assis overlooked the first was consistent with facility that were al The window and fra marking other than unknown if the win fire-rated glazing met the fire resistant opening. Based on observation, Facilithe thought the fram magnet on his iPad frame when tested, frame was not mark. This finding was re Director, Facilities	the second floor contained a sted living seating area which e-floor atrium entry area, which to other corridor windows in the uminum frame construction. It is a steer and it was dow was provided with a steer all or if the aluminum frame are requirements for a vertical interview at the time of ites Management Support said the was aluminum and the cover didn't magnetize to the and agreed the window and atted with a fire-rated identifier. Viewed with the Executive Management Support and perations at the exit conference.		Trilogy Support and the Dire Plant Operations have cont the appropriate vendors to the window with a window a frame that meets the properequirements for window gland frame fire resistance in vertical open space in accowith LSC 8.3.3. 4 Corrective Actions the will be monitored to ensural leged will not reoccur: The Director of Plant Operand/or Designee will ensure the new assembly is complimited by the which states that new fire protection-rated glazing shamarked in accordance with 8.3.3.12 and Table 8.3.4.2, such marking shall be permanently affixed.	acted replace and r azing a rdance hat te the ations that ant LSC all be Table
SS=F Bldg. 01	failed to ensure 4 of as fuel-fired heater	- Enclosure on and interview, the facility f over 10 hazardous areas such rooms and laundry rooms were er spaces by smoke resistant	K 0321	Corrective Action for resident(s) affected by the alleged deficient practice:	

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	PROVIDER OR SUPPLIER			395 8TH	ADDRESS, CITY, STATE, ZIP COD H AVENUE HAUTE, IN 47804		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	or automatic closing	Doors shall be self closing in accordance with 7.2.1.8. ice could affect all residents, the facility.			This deficient practice could haffected all Residents, Staff ar Visitors.		
	Based on observation Director, Facilities of Director, Facilities of Director of Plant Optical facility from 12:51 corridor door to the room was equipped latching hardware be close and latch into close multiple times corridor door labeled room 206 was to a furnace, which was device and latching to latch into the door on the door was tap the door, as well as frame was completed Plant Operations reposservation and the the frame when test containing fuel fired and receiving plates.	ons with the Executive Management Support and perations during a tour of the p.m. to 3:00 p.m. on 03/10/25, the soiled side of the laundry with a self closing device and out the door failed to fully self the door frame when tested to s. In addition, at 1:10 p.m. the od A138 across from resident room containing a fuel fired equipped with a self closing hardware but the door failed or frame when tested. The latch ed over to hold the latch in the receiving plate on the ely taped over. The Director of moved the tape at the time of door positively latched into ed. The following rooms d furnaces had the door latches staped over as well: furnace			2 Corrective Actions take for those resident(s) having a potential to be affected by the alleged deficient practice: No Residents, staff or visitors were identified or reported any findings suggestive of having affected by the deficient practice affected by the deficient practice changes put in place to ensure the alleged deficient practice does not recur: The Director of Plant Operation removed the tape immediately the three doors in the hallways.	the e / been ce. c ire ns / on s.	
	across from residen at the time of the ob- Plant Operations ag hazardous areas we spaces by smoke res These findings were Director, Facilities	00 Nurse station, furnace room t room 103. Based on interview beervations, the Director of reed the aforementioned re not separated from other sistant partitions and doors. e reviewed with the Executive Management Support and perations during the exit			The Director of Plant Operation has fixed the door leading to soiled laundry so that the self-closing device latches properly. 4 Corrective Actions that will be monitored to ensure the alleged will not re occur:	t	
	conference.						

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155830	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/10/2025
	PROVIDER OR SUPPLIER		395 8T	ADDRESS, CITY, STATE, ZIP COD TH AVENUE E HAUTE, IN 47804	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K 0324 SS=E	NFPA 101			The Director of Plant Operation and/or Designee developed a weekly door latching audit. The Director of Plant Operations a Designee will perform the observation audits three times week, for three months. The Director of Plant Operations a Designee will educate all visit vendors on our policy on self-closing and latching doors Findings will be reviewed durithe quarterly QA Committee in order to determine the freques for ongoing monitoring. Finding suggestive of 100% complian may result in cessation of the monitoring plan based on reviewed.	he and/or s a and/or ing s. ng n ncy ngs ce
Bldg. 01	failed to ensure 1 of suppression system accordance with NF NFPA 96, Standard Fire Protection of C Operations. NFPA states automatic fire be installed in accord	on and interview, the facility of 1 kitchen range hood fire s was maintained in FPA 96. LSC 9.2.3 refers to for Ventilation Control and commercial Cooking 96, 2011 Edition, Section 10.2.6 e-extinguishing systems shall rdance with the terms of their turer's instructions, and the	K 0324	Corrective Action for the resident(s) affected by the alleged deficient practice: This deficient practice could affected 5 kitchen staff. Corrective Actions take for those resident(s) having potential to be affected by the alleged deficient practice:	nave en the

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	<u>01</u>	COMPLETED
		155830	B. WI	NG		03/10/2025
	PROVIDER OR SUPPLIER			395 8T	ADDRESS, CITY, STATE, ZIP COD H AVENUE E HAUTE, IN 47804	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	(4) NFPA 17A					
		1 4.3.1.5 states all discharge			No Residents, staff or visitors	
	_	ovided with caps or other			were identified or reported any	
	_	prevent the entrance of grease			findings suggestive of having	
	_	r other foreign materials.			affected by the deficient pract	ice.
		es the protection device shall				
	blow out upon agent discharge. This deficient practice could affect over five staff in the kitchen.					
	Findings include:				3 Corrective Actions	
	rindings include.				including Measures/Systemi changes put in place to ensu	
Based on observations with the Executive				the alleged deficient practice		
	Director, Facilities Management Support and				does not recur:	·
	Director of Plant Operations during a tour of the				does not recur.	
		p.m. to 3:00 p.m. on 03/10/25,				
	-	e nozzle caps for the facility's			The Director of Plant Operation	ins
	_	appression systems were not in			replaced nozzle cap on the or	
		gling. Based on interview at			nozzle that was not in place	
	-	ervation, the Director of Plant			correctly.	
		he nozzle cap was not in place			1 1	
		e hood fire suppression				
	system.				4 Corrective Actions tha	t
					will be monitored to ensure	the
	This finding was re	viewed with the Executive			alleged will not re occur:	
		Management Support and				
		perations during the exit			The Director of Plant Operation	ons
	conference.				and/or Designee developed a	
					weekly Kitchen Range Hood	
	3.1-19(b)				audit. The Director of Plant	
					Operations and/or Designee v	
					perform the observation audits	3
					three times a week, for three	1
					months. Findings will be revie	wea
					during the quarterly QA	no
					Committee in order to determine	ile
					the frequency for ongoing	vo of
					monitoring. Findings suggesting 100% compliance may result	
					cessation of the monitoring pla	
					based on review	411

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155830	A. BUILDING <u>01</u> B. WING		X3) DATE SURVEY COMPLETED 03/10/2025			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 395 8TH AVENUE TERRE HAUTE, IN 47804				
(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 APPROPRIAT DEFICIENCY)	rE	(X5) COMPLETION DATE		
K 0353 SS=E Bldg. 01	1. Based on observation failed to maintain the Physical Therapy romaintain the Physical Therapy romaintain section 3.3.5.4 definitions of the observation failed to maintain the Physical Therapy romaintain section for the properties of the propert	on with the Executive Director, tent Support and Director of tering a tour of the facility at 25, two suspended ceiling tiles Physical Therapy room, which above. The room was ant sprinklers installed on the Based on interview at the time the Executive Directoring ceiling tiles in Physical ere was a recent ceiling leak is	K 0	353	1 Corrective Action for the resident(s) affected by the alleged deficient practice: This deficient practice could he affected 10 Residents, Staff ar Visitors in the Therapy Gym are two Staff in Laundry. 2 Corrective Actions take for those resident(s) having the potential to be affected by the alleged deficient practice: No Residents, staff or visitors were identified or reported any findings suggestive of having the affected by the deficient practice. 3 Corrective Actions including Measures/Systemic changes put in place to ensurthe alleged deficient practice does not recur:	ave and and he been ce.	04/04/2025	
	This finding was re	viewed with the Executive			The Director of Plant Operation	ns		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155830	B. W	ING		03/10/2025		
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIEF	8			H AVENUE			
HARRIS	ON'S CROSSING H	HEALTH CAMPUS		TERRE HAUTE, IN 47804				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	Director, Facilities Management Support and Director of Plant Operations at the exit conference.				replaced the two ceiling tiles in			
					Therapy gym. The Director of			
					Plant Ops cleaned the sprinkle			
		ation, and interview; the			head in laundry in accordance			
		sure all sprinkler heads in the			the code using a vacuum that	did		
	1	ered with lint were replaced or			not touch the sprinkler.			
		nce with NFPA 25. NFPA 25,			Director of Plant operations w	as		
		spection, Testing, and			educated on the following:			
		iter-Based Fire Protection			Sprinkler System – Maintenar			
	Systems, 2011 Edition, Section 5.2.1.1.1 states				and Testing Automatic sprinkl	er		
	sprinklers shall not show signs of leakage; shall				and standpipe systems are			
	be free of corrosion, foreign materials, paint, and				inspected, tested, and mainta	ined		
	physical damage; and shall be installed in the				in accordance with NFPA 25,			
		(e.g., up-right, pendent, or			Standard for the Inspection,			
		nore, at 5.2.1.1.2 any sprinkler			Testing, and Maintaining of			
	_	any of the following shall be			Water-based Fire Protection			
	replaced:				Systems. Records of system			
	(1) Leakage				design, maintenance, inspecti			
	(2) Corrosion				and testing are maintained in	a		
	(3) Physical Damag				secure location and readily			
	1 ' '	the glass bulb heat responsive			available.			
	element							
	(5) Loading	nainted by the annials or						
	manufacturer.	painted by the sprinkler			4 Corrective Actions tha			
		sprinklers that are loaded with			4 Corrective Actions tha will be monitored to ensure			
		to clean sprinklers with				ine		
	_	by a vacuum provided that the			alleged will not re occur:			
	1 ^	touch the sprinkler.			The Director of Plant Operation	one		
		ice could affect two staff in the			and/or Designee developed a	JIIO		
	Laundry room.	22 Isaia arrow two start in the			weekly Sprinkler System audi			
	Lucinary 100iii.				The Director of Plant Operation			
	Findings include:				and/or Designee will perform			
	I manago morado.				observation audits three times			
	Based on observation	on with the Executive Director,			week, for three months. Finding			
		nent Support and Director of			will be reviewed during the	'9°		
	1	uring a tour of the facility at			quarterly QA Committee in ord	der		
		25, the sprinkler located above			to determine the frequency for			
	_	Laundry room was covered			ongoing monitoring. Findings			
		interview at the time of			suggestive of 100% compliant	re		

STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED	
		155830	B. WI	NG		03/10/	2025	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD	Ь		
NAME OF P	ROVIDER OR SUPPLIER	L.						
LIADDICA	ON'S CROSSING H	IEALTH CAMPLIS		395 8TH AVENUE				
HARRISC	JN 3 CROSSING H	IEALTH CAIVIPUS		TERRE HAUTE, IN 47804				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	observation, the Dir	rector of Plant Operations			may result in cessation of the			
	-	ntioned automatic sprinkler			monitoring plan based on revie	∍w.		
	was loaded with lint.							
	This finding was reviewed with the Executive Director, Facilities Management Support and							
	Director of Plant Op	perations at the exit conference.						
Director of Plant								
	3.1-19(b)							
V 0704	NEDA 404							
K 0781 SS=F	=F Portable Space Heaters							
Bldg. 01	Događ on rogand rot	viary and interview the	17.0	701			04/04/2025	
	Based on record review and interview, the facility's policy addressing the use of portable		K 0	/81	1 Corrective Action for th		04/04/2025	
	space heaters in the facility did not prohibit the					е		
	use of portable space heaters in resident areas in				resident(s) affected by the			
		e requirements of NFPA 101 -			alleged deficient practice:			
		on 19.7.8. Section 19.7.8 states			This deficient practice could h	2010		
		ing devices shall be prohibited			affected all Resident, Staff and			
	-	cupancies, unless both of the			Visitors.	1		
		re met: (1) Such devices are			Visitors.			
	-	eping staff and employee						
	areas (2) The heating elements of such devices do							
	not exceed 212F (100C). This deficiency could				2 Corrective Actions take	en		
	affect all residents, staff and visitors. Findings include:				for those resident(s) having t	_		
					potential to be affected by th			
					alleged deficient practice:	-		
	Based on record review with the Executive				No Residents, staff or visitors			
	Director and Facilit	ies Management Support on			were identified or reported any	,		
	03/10/25 at 12:50 p.	.m., review of the document			findings suggestive of having l	peen		
	titled "Portable Hea	ters Policy Life Safety" with a			affected by the deficient practi			
	revised date of 08/2	8/2019, revealed that the						
	wording was not cle	ear that portable space heaters						
	were only allowed i	n non-sleeping employee						
		ated that portable space			3 Corrective Actions			
	•	d in non-patient care or			including Measures/Systemic	3		
	-	nt areas. The policy stated			changes put in place to ensu	re		
	patient care areas w	ere loosely defined as a smoke			the alleged deficient practice	;		

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155830		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/10/2025	
	PROVIDER OR SUPPLIER		395 8T	ADDRESS, CITY, STATE, ZIP COD H AVENUE E HAUTE, IN 47804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	treatment activities. misinterpreted and ple used in areas oth employee areas. Ba record review, the Espace heater policy portable space heater non-sleeping emplo This finding was co	This wording could be portable space heaters could er than non-sleeping staff and sed on interview at the time of executive Director agreed the did not clearly state that ers were only allowed in yee areas. Infirmed by the Executive rector of Plant Services at the		The Portable Space Heater phas been updated to reflect the space heating devices shall be prohibited in all health care occupancies, except, unless in nonsleeping staff and empareas where the heating elendonot exceed 212 degrees Fahrenheit. 4 Corrective Actions the will be monitored to ensure alleged will not reoccur: The new Portable Space He policy will be reviewed during quarterly QA Committee in or to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliar may result in cessation of the monitoring plan based on rev	hat pe used loyee nents at the ater p the rder pr	
K 0920 SS=E Bldg. 01	Extens Based on observation failed to ensure a mas a substitute for final 19.5.1 requires utility LSC 9.1.2 requires	ent - Power Cords and on and interview, the facility ulti plug adapter was not used xed wiring in the facility. LSC ties to comply with Section 9.1. electrical wiring and equipment PA 70, National Electrical Code,	K 0920	Corrective Action for tresident(s) affected by the alleged deficient practice: This deficient practice had the second seco		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155830		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/10/2025				
NAME OF PROVIDER OR SUPPLIER HARRISON'S CROSSING HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP COD 395 8TH AVENUE TERRE HAUTE, IN 47804					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	2011 Edition. NFP unless specifically personal cables shall not be wiring of a structure affect at least 10 res	A 70, Article 400.8 requires that, permitted, flexible cords and used as a substitute for fixed e. This deficient practice could edidents and five staff in one		potential to affect 10 Resider and five staff in one smoke compartment	nts		
	smoke compartment Findings include: Based on observation during a tour of the Director, Facilities Director of Plant Of electronic picture for electrical equipment adapter in resident that the time of observation confirmed the use of resident room 218. This finding was re			2 Corrective Actions tall for those resident(s) having potential to be affected by the alleged deficient practice: No residents, staff or visitors identified or reported any find suggestive of having been after by the deficient practice. 3 Corrective Actions including Measures/System changes put in place to asset the alleged deficient practice.	the he swere lings fected		
	Director of Plant Option Conference. 3.1-19(b)	perations during the exit		The Director of Plant Operatimmediately removed the multi-plug adapter from room The Executive Director and/designee provided re-education the Director of Plant Operation Electrical Equipment - Power Cords and Extension CFR(s) NFPA 101 Power strips in a patient care vicinity are only of for components of movable patient-care-related electrical equipment (PCREE) assembly that have been assembled by qualified personnel and meet	218. or ion to ons on : : used		

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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER 155830	A. BUILDING B. WING	01	COMPLETED 03/10/2025
	ROVIDER OR SUPPLIER DN'S CROSSING H		395 8T	ADDRESS, CITY, STATE, ZIP COD H AVENUE E HAUTE, IN 47804	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				conditions of 10.2.3.6. Power strips in the patient care vicini may not be used for non-PCR (e.g., personal electronics), except in long-term care resid rooms that do not use PCREE Power strips for PCREE meet 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside or vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standard All power strips are used with general precautions. Extension cords are not used as a substrips for fixed wiring of a structure. Extension cords used temporare removed immediately upon completion of the purpose for which it was installed and meet the conditions of 10.2.4.10.2.3 (NFPA 99), 10.2.4 (NFPA 99) 400-8 (NFPA 70), 590.3	ety REE dent E. t UL f er ds. en citute arily en ets 3.6
				4 Corrective Actions the will be monitored to ensure alleged will not re occur:	
				The Director of Plant Operati and/or Designee developed a weekly audit that includes monitoring the usage of any patrips or multi plug adapters in Resident rooms. The Director Plant Operations and/or Designations	oower n of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155830		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 03/10/2025			ETED	
NAME OF PROVIDER OR SUPPLIER HARRISON'S CROSSING HEALTH CAMPUS				395 8TH	ADDRESS, CITY, STATE, ZIP COD H AVENUE HAUTE, IN 47804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipm Maintenanc Based on records reinterview, the facilirequired maintenand documentation of it Related Electrical It 2012 edition, section physical integrity, touch current tests is performed as require established with PCREE used in pattiaccordance with 10 into service and aft Any system consist appliances demons 99 as a complete syinstructions, and promanufacturer inclusions. 3.1.1 and are confused in the program for electrical equipments.		K 09		will perform the observation at three times a week, for three months. Findings will be review during the quarterly QA Committee in order to determit the frequency for ongoing monitoring. Findings suggestive 100% compliance may result it cessation of the monitoring plates based on review. 1 Corrective Action for the resident(s) affected by the alleged deficient practice: This deficient practice could haffected all Residents 2 Corrective Actions take for those resident(s) having a potential to be affected by the alleged deficient practice: No Residents, staff or visitors were identified or reported any findings suggestive of having a finding suggestive of h	wed ne /e of in an te ave en the ie	04/04/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u> COMPLETED			COMPLETED			
	155830		B. W	ING	03/10/2025			
				CTREET	ADDRESS CITY STATE ZID COD			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
LIADDICONIO ODOCCINO LIEALTIL CAMBUIO				395 8TH AVENUE				
HARRISON'S CROSSING HEALTH CAMPUS				TERRE	HAUTE, IN 47804			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	and condensed oper	rating instructions on the			3 Corrective Actions			
	appliance are legible	e. A record of electrical			including Measures/Systemic	c		
	equipment tests, rep	pairs, and modifications is			changes put in place to ensu			
	maintained for a per	riod of time to demonstrate			the alleged deficient practice			
	compliance in accor	dance with the facility's			does not recur:			
	policy. Personnel re	sponsible for the testing,						
		e of electrical appliances						
		training. This deficient			The Director of Plant Operatio	ns		
	practice affects all r				has completed inspections for			
	•				Patient Care Related Electrica			
	Findings include:				Equipment (PCREE) in			
	C				accordance with 10.3.5.4 or			
	Based on records re	view with Facilities			10.3.6, which states that all			
		ort (FMS) and Director of Plant			PCREE is tested prior to servi	ce		
		0/25 between 9:30 a.m. and						
	-	lete documentation was			or after any repair or modificat			
		for the testing of the PCREE in						
		facility, as required by section			4 Corrective Actions that	_f		
		9, Health Care Facilities Code.			will be monitored to ensure t			
		ent Support stated he was			alleged will not re occur:			
	_	the requirement and started						
	_	/25 and got one wing			The Director of Plant Operation	ons		
		ainder of the facility has not			and/or Designee developed a			
	_	s survey. Observation during			weekly PCREE audit of PCRE	F		
		vealed that the facility			documentation. The Director			
	provided electric be	_			Plant Operations and/or Desig			
	•				will perform the observation at			
	This finding was re-	viewed with the Executive			one time per week, for three			
		Management Support and			months. Findings will be review	wed		
		perations at the exit conference.			during the quarterly QA			
					Committee in order to determine	ne		
	3.1-19(b)				the frequency for ongoing			
	(-)				monitoring. Findings suggestive	ve of		
					100% compliance may result i			
					cessation of the monitoring pla			
					based on review.	""		
					Sacca off Toviovy.			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/03/2025 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MUL			LTIPLE CO	ONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	A. BUILDING 01			COMPLETED	
		155830	B. WING			03/10/2025		
NAME OF PROVIDER OR SUPPLIER HARRISON'S CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 395 8TH AVENUE TERRE HAUTE, IN 47804				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	

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