DEPARTMENT	OF HEALTH AND HUMAN SERVICES
CENTERS FOR	MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER HARRISON'S CROSSING HEALTH CAMPUS (X94) DISCRIPTION OF DEPICIENCE (EACH DETICIENCY MOST BE PRECEDED BY FULL REGILATORY OR LSC IDENTIFYING INFORMATION E 0000 Bidg An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 20 CFR 483.73. An Intergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. An Emergency Preparedness survey, Harrison's Crossing Health Campus was found in compliance with Emergency Preparedness survey, Harrison's Crossing Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicard Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 72 certified beds and had a ceasus of 50 at the time of this visit. Quality Review completed on 11/28/22 K 0000 Bidg. 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). K 0000 Bidg. 01 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Thealth in accordance with 42 CFR 483.90(a).		NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155830	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE COMPL 11/23	ETED
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TO A THE SUBMISSION OF THIS PLAN PROPERTIES. An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/23/22 An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/23/22 At this Emergency Preparedness survey, Harrison's Crossing Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 72 certified beds and had a census of 50 at the time of this visit. Quality Review completed on 11/28/22 K 0000 Bidg. 01 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR					395 8T	H AVENUE		
An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/23/22 Facility Number: 013335 Provider Number: 155830 AIM Number: 201290670 At this Emergency Preparedness survey, Harrison's Crossing Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 72 certified beds and had a census of 50 at the time of this visit. Quality Review completed on 11/28/22 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 The submission of this plan of correction does not indicate an admission by Harrison's Crossing Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of the quality of care provided, and living environment provided to the residents of participation for provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 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	PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
Bldg. 01 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR	Bldg	conducted by the In accordance with 42 Survey Date: 11/23 Facility Number: 0 Provider Number: 201 At this Emergency Harrison's Crossing compliance with Er Requirements for N Participating Provid 483.73 The facility has a can had a census of 50 and a census of 50 and accordance with Er Requirements for N Participating Provides 483.73	diana Department of Health in CFR 483.73. 8/22 13335 155830 290670 Preparedness survey, Health Campus was found in mergency Preparedness fedicare and Medicaid ders and Suppliers, 42 CFR apacity of 72 certified beds and at the time of this visit.	E 0	000	correction does not indicate a admission by Harrison's Cros Health Campus that the findin and allegations contained her are accurate, true representat of the quality of care provided living environment provided to residents of Harrison's Crossi Health Campus. The facility recognizes its obligation to prolegally and medically necessal care and services to its reside in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirem of participation for skilled heal care facilities. To this end, the plan of correction shall serve the credible allegation of compliance with all state and federal requirements governing management of this facility. It thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for	n sing sing sing sing sing sing sing sin	
A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR K 0000 The submission of this plan of correction does not indicate an admission by Harrison's Crossing	K 0000							
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		Licensure Survey w Department of Heal 483.90(a).	vas conducted by the Indiana Ith in accordance with 42 CFR			correction does not indicate a admission by Harrison's Cros Health Campus that the findin	n sing	

(X6) DATE

Sean Medsker **Executive Director** 12/12/2022

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155830	B. Wl	ING		11/23/2022	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			H AVENUE		
HARRISO	ON'S CROSSING H	EALTH CAMPUS	TERRE HAUTE, IN 47804				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROP		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	i	TAG	DEFICIENCY)		DATE
	G D 11/00	1/22			and allegations contained here		
	Survey Date: 11/23	0/22			are accurate, true representati		
	Facility Number: 01	12225			of the quality of care provided,		
	Provider Number: 1				living environment provided to residents of Harrison's Crossir		
	AIM Number: 2012				Health Campus. The facility	ig	
	7 11 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				recognizes its obligation to pro	ovide	
	At this Life Safety (Code survey, Harrison's			legally and medically necessa		
		mpus was found not in			care and services to its reside	-	
	_	equirements for Participation in			in an economic and efficient		
	Medicare, 42 CFR Subpart 483.90(a), Life Safety				manner. The facility hereby		
	from Fire and the 2012 edition of the National Fire				maintains it is in substantial		
	Protection Association (NFPA) 101, Life Safety				compliance with the requireme	ents	
	Code (LSC), Chapte	er 19, Existing Health Care			of participation for skilled heal		
	Occupancies and 41	0 IAC 16.2.			care facilities. To this end, the		
					plan of correction shall serve a	as	
	This facility was loo	cated on the first floor of a two			the credible allegation of		
		mined to be of Type V (111)			compliance with all state and		
		as fully sprinklered. The			federal requirements governin	g the	
		arm system with hard wired			management of this facility. It	is	
		the corridors, spaces open to			thus submitted as a matter of		
		ll resident rooms. The entire			statute only. The facility		
		ility, including the Legacy			respectfully requests from the		
		ng unit was surveyed due to			department a desk review for		
		fire-rated separation. Legacy			substantial compliance.		
		ng unit includes rooms 113					
	- '	ds). The facility has a capacity or including the Legacy					
		or including the Legacy ng unit, with 72 certified beds					
		50 at the time of this survey.					
	and had a census of	50 at the time of this survey.					
	All areas where resi	idents have customary access					
		d all areas providing facility					
	-	klered, except a detached					
	maintenance garage used for the storage of maintenance equipment.						
	Quality Review con	npleted on 11/28/22					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 155830 B. WING		ICTION	(X3) DATE SURVEY COMPLETED 11/23/2022				
	PROVIDER OR SUPPLIE DN'S CROSSING H			395 8TH	H AVE	SS, CITY, STATE, ZIP COD ENUE TE, IN 47804		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE ISS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG		DEFICIENCY)		DATE
K 0918	NFPA 101							
SS=F	Electrical Systems	s - Essential Electric Syste						
Bldg. 01	Electrical System	s - Essential Electric						
	System Maintena	nce and Testing						
	The generator or	other alternate power						
	-	iated equipment is capable						
		ce within 10 seconds. If the						
		on is not met during the						
		ocess shall be provided to						
	•	this capability for the life						
	safety and critical	branches. Maintenance						
	· ·	generator and transfer						
	_	ormed in accordance with						
	NFPA 110.							
		e inspected weekly,						
		oad 30 minutes 12 times a						
	vear in 20-40 day	intervals, and exercised						
		onths for 4 continuous hours.						
		nder load conditions include						
		ated cold start and						
	=	ual transfer of all EES						
		nducted by competent						
		enance and testing of stored						
	-	rces (Type 3 EES) are in						
		NFPA 111. Main and feeder						
		re inspected annually, and a						
		dically exercising the						
		tablished according to						
		uirements. Written records						
		nd testing are maintained						
		ble. EES electrical panels						
	_	narked, readily identifiable,						
		n normal power circuits.						
	•	ssibility of damage of the						
		r source is a design						
	consideration for							
		(NFPA 99), NFPA 110,						
	NFPA 111, 700.1	,						
		review and interview, the	K 0	918	1.	Corrective Action for t	the	12/12/2022
		mpletely document the		710		dent(s) affected by the		12/12/2022

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Event ID:

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155830	B. W	ING _		11/23/	/2022
		l .		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			H AVENUE		
HVDDIG	ON'S CROSSING H	IEALTH CAMPUS		TERRE HAUTE, IN 47804			
TARRI30	DIN 3 URUSSING F	IEAL I IT CAWIFUS		TERRE HAUTE, IN 47804			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP		(EACH CORRECTIVE ACTION SHOULD BE	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		enerator for 9 of 12 months to			alleged deficient practice:		
	meet the requirements of NFPA 110, 2010 Edition,				This deficient practice did not	have	
	the Standard for En	nergency and Standby Powers			the potential to affect any		
	Systems, Chapter 8	.4.2. Section 8.4.2 states diesel			Residents.		
	generator sets in service shall be exercised at least						
	_	minimum of 30 minutes, using					
	one of the following	~					
	I	aintains the minimum exhaust			2. Corrective Actions tak	(en	
		recommended by the			for those resident(s) having		
	manufacturer				potential to be affected by th	ie	
	(2) Under operating temperature conditions and at				alleged deficient practice:		
		cent of the EPS (Emergency					
	Power Supply) nameplate kW rating.				No resident's, staff or visitors		
		es diesel-powered EPS			were identified or reported any	y	
		not meet the requirements of			findings suggestive of having	been	
		ised monthly with the available			affected by the deficient practi	ice.	
		Power Supply System) load and					
		nnually with supplemental					
		in 50 percent of the EPS					
	_	ng for 30 continuous minutes			3. Corrective Actions		
		75 percent of the EPS			including Measures/Systemi	С	
		ng for 1 continuous hour for a			changes put in place to assu		
		f not less than 1.5 continuous	the alleged deficient practice				
		nt practice could affect all			does not re occur:		
	occupants.						
					The Director of Plant Ops or		
	Findings include:				designee will now calculate th		
					actual load percentage for the	!	
		generator load testing			diesel-powered generator.		
		n the Director of Plant			l		
	_	3 a.m. on 11/23/22, the load			The diesel-powered generato		
		v the actual load percentage for			currently set up for a monthly		
	_	generator was not documented			test of 45 minutes followed by	а	
	_	h November 2022. Based on			15 minute cool down.		
		ne of record review, the Director					
	of Plant Operations stated the diesel generator ran						
	under load on a mo	-					
	documentation does				4. Corrective Actions tha		
	percentage of the na	ame plate rating.			will be monitored to ensure t	the	
			1		alleged will not re occur:		İ

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155830		,	JILDING	onstruction 01	(X3) DATE (COMPL 11/23/	ETED
		133630	D. W1	_		11/23/	2022
	ROVIDER OR SUPPLIER DN'S CROSSING H			395 8TH	ADDRESS, CITY, STATE, ZIP COD H AVENUE HAUTE, IN 47804		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	(X5) COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2. Based on record facility failed to ensugenerators was allowered after a load to 2012 NFPA 99 requested for Emergency and Chapter 8. NFPA 1 Shutdown requires minutes shall be prothe Emergency Powshutdown. This delaction on small (15 kW or This deficient practices)	review and interview, the sure 1 of 1 emergency wed a 5 minute cool down est. Chapter 6.4.4.1.1.4(a) of the sures monthly testing of the sure emergency electrical system with NFPA 110, the Standard Standby Powers Systems, 10, 6.2.10 Time Delay on Engine that a minimum time delay of 5 ovided for unloaded running of the yer Supply (EPS) prior to any provides additional engine sure delay shall not be required less) air-cooled prime movers. ice could affect all residents, visitors in the facility.			The Director of Plant Operation and/or Designee will utilize our monthly load bank test and percentage audit. DPO and/or designee will report on load be percentages as well as confirm a 15 minute cool down. The Director of Plant Operations at Designee will perform the observation audits monthly. Findings will be reviewed during the quarterly QA Committee in order to determine the frequent for ongoing monitoring.	ank ning nd/or	
		view with the Director of Plant 3/22 at 10:38 a.m., the Monthly			5. The time frame the campus is alleging compliance.		
	generator log form tested monthly for a however, there was that showed the ger following its load to time of record revie Operations stated the down period after the agreed the cool down. These findings were	documented the generator was at least 30 minutes under load, no documentation on the form learner had a cool down time lest. Based on interview at the lew, the Director of Plant lee diesel generator has a cool lee monthly load test, and was not documented. The reviewed with the Executive learner of Plant Operations at the			Date: December 12, 2022		
K 0920 SS=B	NFPA 101 Electrical Equipme	ent - Power Cords and					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/14/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155830	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/23/2022
	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 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
Bldg. 01	Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by quathe conditions of 1 the patient care vinnon-PCREE (e.g., except in long-terr do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care reother UL standard used with general cords are not used wiring of a structure temporarily are recompletion of the pinstalled and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.3 (Based on observation review, the facility of cords were not used wiring. LSC 19.5.1 Section 9.1. LSC 9 and equipment to confer in the properties of the properties o	d electrical equipment	K 0920	1. Corrective Action for the resident(s) affected by the alleged deficient practice: This deficient practice did not the potential to affect any Residents. 2. Corrective Actions take for those resident(s) having the potential to be affected by the alleged deficient practice:	have cen the

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Event ID:

AFPW21 Facility ID: 013335

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	CIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED				ETED
		155830	B. WI	ING		11/23/	2022
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
LIADDIO		IEAL THE CAMPILO			H AVENUE		
HARRIS	ON'S CROSSING F	IEALTH CAMPUS		TERRE	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	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	This deficient practice could affect staff and				No resident's, staff or visitors		
	_	ity of the conference room.			were identified or reported any		
	visitors in the violanty of the conference room.				findings suggestive of having		
	Findings include:				affected by the deficient practi		
	8						
	Based on observation	on with the Director of Plant					
		3/22 at 9:35 a.m., a portable					
	_	ugged into a power strip in the			3. Corrective Actions		
		ased on interview at the time			including Measures/Systemi	c	
		the Director of Plant			changes put in place to assu		
	·	a portable space heater was			the alleged deficient practice		
		er strip was being used as a			does not re occur:	'	
		wiring at the aforementioned			does not re occur.		
		ole space heater was					
	_	power strip by the Director of					
		the time of observation. Based			The Everything Discretes and/o	_	
	_				The Executive Director and/o		
		11/23/22 at 11:35 a.m., the			designee provided re-education	on to	
		able space heaters in			all Department Heads on		
	non-patient areas.				Electrical Equipment - Power		
					Cords and Extension cords		
	_	viewed with the Executive			CFR(s): NFPA 101 Power stri		
		rector of Plant Operations			a patient care vicinity are only		
	during the exit conf	erence.			used for components of mova	ble	
					patient-care-related electrical		
	3.1-19(b)				equipment (PCREE) assemble		
					that have been assembled by		
					qualified personnel and meet	the	
					conditions of 10.2.3.6. Power		
					strips in the patient care vicini		
					may not be used for non-PCR	EE	
					(e.g., personal electronics),		
					except in long-term care resid	ent	
					rooms that do not use PCREE	<u>:</u> .	
					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, powe	r	
					strips meet other UL standard		
	I		I		Sampo moot other or standard	۷.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/14/2022 FORM APPROVED OMB NO. 0938-039

	F CORRECTION CONTROL TO THE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE		(X3) DATE SURVEY COMPLETED 11/23/2022		
	ROVIDER OR SUPPLIE	R HEALTH CAMPUS	395 8T	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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				All power strips are used with general precautions. Extensic cords are not used as a substor fixed wiring of a structure. Extension cords used temporare removed immediately upocompletion of the purpose for which it was installed and methe conditions of 10.2.4.10.2. (NFPA 99), 10.2.4 (NFPA 99) 400-8 (NFPA 70), 590.3 The Director of Plant Operation immediately unplugged the sheater from the power strip in conference room on the day inspection 11/23/2022. 4. Corrective Actions the will be monitored to ensure alleged will not re occur:	n con dititute rarily con freets 3.6), ions pace in the of the
				The Director of Plant Operat and/or Designee developed a weekly audit that includes monitoring the usage of any strips in any office space. Th Director of Plant Operations Designee will perform the observation audits three time week, for three months. Find will be reviewed during the quarterly QA Committee in or to determine the frequency for ongoing monitoring. Findings suggestive of 100% complian	power e and/or s a ings rder or

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/14/2022 FORM APPROVED OMB NO. 0938-039

	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 11/23/2022
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	
HARRISO	ON'S CROSSING H	EALTH CAMPUS		TH 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	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
				may result in cessation of the monitoring plan based on re	
				5. The time frame the campus is alleging compliance.	
				Date: December 12, 2022	
K 0923 SS=B Bldg. 01	Storag Gas Equipment - Storage Greater than or ec Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations enclosure or withi space of non- or li construction, with that can be secure stored with flamm from combustibles sprinklered) or en noncombustible c minimum 1/2 hr. fi Less than or equa ln a single smoke cylinders available patient care areas of less than or equ required to be sto	Cylinder and Container Cylinder and Container qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2 Bubic feet are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) and are separated as by 20 feet (5 feet if closed in a cabinet of construction having a are protection rating. I to 300 cubic feet compartment, individual as for immediate use in a with an aggregate volume and to 300 cubic feet are not ared in an enclosure. I handled with precautions			

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AFPW21 Facility ID: 013335

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155830	B. W	ING		_ 11/23/2022	
NAME OF D	PROVIDER OR SUPPLIER)		STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					H AVENUE		
HARRISO	ON'S CROSSING H	IEALTH CAMPUS		TERRE	HAUTE, IN 47804		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENC!)		DATE
	as specified in 11.						
		ign readable from 5 feet is					
		ate of a cylinder storage sign includes the wording as					
		FION: OXIDIZING GAS(ES)					
	STORED WITHIN	` ,					
		d so cylinders are used in					
		ey are received from the					
		ylinders are segregated					
		. When facility employs					
		gral pressure gauge, a					
	threshold pressure considered empty is						
	established. Empty cylinders are marked to						
	·	Cylinders stored in the open					
	are protected from						
		.3.3, 11.3.4, 11.6.5 (NFPA					
	99)	, , ,					
	,	on and interview, the facility	K 0	923	Corrective Action for the		12/12/2022
	failed to ensure 1 of	f 1 cylinders of nonflammable			resident(s) affected by the		
	gases such as oxyge	en were properly secured from			alleged deficient practice:		
	falling. NFPA 99, l	Health Care Facilities Code,			This deficient practice had the	!	
	2012 Edition, Section	on 11.3.2 states storage for			potential to affect one resident	ts in	
	_	s greater than 8.5 cubic meters		one room. 2. Corrective			
	` /	less than 85 cubic meters		Actions taken for those			
	,	nall comply with 11.3.2.1			resident(s) having the potent	tial	
	_	NFPA 99, Section 11.3.2.6 states			to be affected by the alleged		
	-	er restraints shall comply with			deficient practice:No residen		
		1.6.2.3(11) states freestanding			staff or visitors were identified		
		roperly chained or supported			reported any findings suggest	ive of	
		stand or cart. This deficient			having been affected by the		
	_	et at least 15 residents and staff			deficient practice. 3.		
	in the vicinity of res	sident room 128.			Corrective Actions including		
	Findings :11				Measures/Systemic changes	i	
	Findings include:				put in place to assure the		
	Rosed on observation	on with the Executive Director			alleged deficient practice do	es	
		on with the Executive Director of the Operations during a tour of			not re occur:	tod	
		p.m. on 11/23/22, one 'E' type			The Charge nurse was educated by the executive director on N		
	-	as standing upright on the floor			99 11.3.1, 11.3.2, 11.3.3, 11.3		
		ridor door of resident room 128.			11.6. health Care facilities coo		
	1 5		1		1	,	1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/14/2022 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 155830 B. WING			(X3) DATE SURVEY COMPLETED 11/23/2022	
	PROVIDER OR SUPPLIEI		395 8T	ADDRESS, CITY, STATE, ZIP COD H AVENUE E HAUTE, IN 47804	
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF The 'E' type oxyger supported in a cyling interview at the time of Plant Operations cylinder in the afort not properly supported 'E secured in the oxygen survey exit.	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION In cylinder was not properly inder stand or cart. Based on ite of observation, the Director is confirmed an 'E' type oxygen itementioned resident room was intended in a cylinder stand or cart. I' type cyclinder was properly item transfill room prior to Inviewed with the Executive item of Plant Operations at the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) 2012 Edition, freestanding cylinders shall be properly char or supported in a proper cylinder stand or cart. The Charge Nurse placed the oxygen cylinder in a chained a immediately on 11/23/2022. The DPO and ED conducted a wall through to identify any other oxygen cylinders not properly secured. No other cylinders widentified on 11/23/2022. 4. Corrective Actions that will monitored to ensure the alleged will not re occur: The Director of Plant Operations a Designee developed a weekly audit that includes monitoring any unsecured oxygen cylinder in Resident rooms or Oxygen Storage rooms. The Director of Plant Operations and/or Design will perform the observation at three times a week, for three months. Findings will be review during the quarterly QA Committee in order to determing the frequency for ongoing monitoring. Findings suggestive to the compliance may result in cessation of the monitoring platased on review. 5. The tiframe the campus is alleging compliance. Date: December	ained der area ne dik were be md/or for ers of gnee udits wed ne we of in an me g
				2022	, l

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