STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155734	A. BUILDING -- B. WING	08/28/2024

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

(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 Date: 08/28/2024 Facility Number: 004075 Provider Number: 155734 AIM Number: 200491220 At this Emergency Preparedness survey, Thornton Terrace 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 55 certified beds. At the time of the survey, the census was 41. Quality Review completed on 08/29/24	E 0000		
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). Survey Date: 08/28/2024 Facility Number: 004075 Provider Number: 155734 AIM Number: 200491220 At this Life Safety Code survey, Thornton Terrace	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Miller	Executive Director	09/04/2024

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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THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

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	Health Campus 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 one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors, and resident rooms 221, 222, 223, 224, and 225, plus battery operated smoke alarms in all other resident rooms. The healthcare portion of the facility has a capacity of 55and had a census of 41 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 08/29/24			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control			

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	system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations through 1 of 1 smoke barrier walls near room 201 was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff, 20 residents, and visitors in this smoke compartment. Findings include: Based on observation during a tour of the facility on 08/28/2024 between 12:30 PM and 2:00 PM with the Director of Plant Operations, a 1.5 inch penetration was located on 1 side of the smoke barrier wall near room 201. Based on interview at the time of the observation, the Director of Plant Operations agreed there was a penetration in the aforementioned location and provided the measurement. This finding was reviewed with the Director of Plant Operations and the Executive Director at the exit conference. 3.1-19(b)	K 0372	The submission of this plan of correction does not indicate an admission by Thornton Terrace Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Thornton Terrace Health Campus. The facility recognizes its obligation to 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 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. Correction to be completed by 9/4/24 **K 372: Subdivision of Building Spaces- Smoke Barrier** Hole in smoke barrier above 201 was immediately repaired No residents were affected by this alleged deficient practice. 20 Health Center residents had the potential to be affected by this alleged deficient practice. Smoke barriers audited with no	09/04/2024

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			additional findings Director of Plant of Operation educated on maintaining smoke barrier walls to ensure areas have no penetrations Director of Plant Operation or designee will audit smoke barrier areas once a week for four months. Twice a month for two months. Then refer to QAPI As a quality measure, the Director of Plant Operation will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	