

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

PRINTED: 03/01/2024  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>155830</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br><br>B. WING _____                       |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><br><b>02/27/2024</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARRISON'S CROSSING HEALTH CAMPUS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>395 8TH AVENUE</b><br><b>TERRE HAUTE, IN 47804</b> |                                                                                                                          |                                                                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |  | ID<br>PREFIX<br>TAG                                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                        | (X5)<br>COMPLETION<br>DATE |
| {K 000}                                                                      | <p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/22/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 02/27/24</p> <p>Facility Number: 013335<br/>Provider Number: 155830<br/>AIM Number: 201290670</p> <p>At this PSR survey, Harrison's Crossing Health Campus was found in compliance with Requirements for Participation in Medicare, 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.</p> <p>This facility was located on the first floor of a two story building determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident rooms. The entire first floor of the facility, including the Legacy Lane-Assisted Living unit was surveyed due to the lack of a 2 hour fire-rated separation. Legacy Lane-Assisted Living unit includes rooms 113 through 122 (11 beds). The facility has a capacity of 83 on the 1st floor including the Legacy Lane-Assisted Living unit, with 72 certified beds and had a census of 57 at the time of this survey.</p> <p>All areas where residents have customary access</p> |                                                                            |  | {K 000}                                                                                        |                                                                                                                          |                                                                        |                            |

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

TITLE

(X6) DATE

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

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| {K 000}                                                                      | Continued From page 1<br>were sprinklered and all areas providing facility<br>services were sprinklered, except a detached<br>maintenance garage used for the storage of<br>maintenance equipment.<br><br>Quality Review completed on 02/29/24 | {K 000}                                                                    |                                                                                                                          |                            |                                                                    |