08/03/2023

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155734	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING COMPLETED B. WING 07/17/2023		LETED	
	PROVIDER OR SUPPLIER		188 TH	ADDRESS, CITY, STATE, ZIP COD ORNTON RD /ER, IN 47243		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL	PREFIX TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	COMPLETION DATE
E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG			DATE
Bldg			E 0000			
	Thornton Terrace H compliance with En Requirements for M Participating Provid 483.73	Preparedness survey, fealth Campus was found in mergency Preparedness fedicare and Medicaid fers and Suppliers, 42 CFR certified beds. At the time of us was 38.				
K 0000						
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 07/17 Facility Number: 0 Provider Number: 2004	04075 155734	K 0000			
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE		(X6) DATE

Stephanie Miller Executive Director

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: U4QR21 Facility ID: 004075 If continuation sheet Page 1 of 16

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155734		UILDING	nstruction 01	(X3) DATE COMPL 07/17 /	ETED	
	PROVIDER OR SUPPLIER		188 TH	DDRESS, CITY, STATE, ZIP COD DRNTON RD ER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
	Health Campus was Requirements for P. Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (I. Health Care Occupation of the facility has a first smoke detection into the corridors, and 224, and 225, plus bein all other resident of the facility has a census of 38 at the facility has a census of 38 at the facility has a census of services were sprinkled and services were sprinkled and Services were sprinkled and Quality Review control of the facility has a census of services were sprinkled and Services were sprinkled services were services were sprinkled services were sprinkled services were spr	a found not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, eSC), Chapter 19, Existing ancies and 410 IAC 16.2. At was determined to be of ruction and fully sprinkled. The alarm system with hard wired the corridors and spaces open a resident rooms 221, 222, 223, eattery operated smoke alarms rooms. The healthcare portion capacity of 55 and had a time of this visit. In the substantial density of the substantial areas providing facility cled.	IAU			DATE
K 0131 SS=F Bldg. 01	Care Facilities Sections of health other occupancies o They are not in more inpatients fo treatment, or custo o They are sepancare occupancies construction ha fire resistance rati accordance with	cies - Sections of Health care facilities classified as a meet all of the following: tended to serve four or r purposes of housing, pomary access. rated from areas of health by aving a minimum two houring in				

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Event ID:

U4QR21 Facility ID: 004075

If continuation sheet Page 2 of 16

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155734	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/17/2023
	PROVIDER OR SUPPLIEI		188 TF	ADDRESS, CITY, STATE, ZIP COD HORNTON RD VER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON (X5) BE COMPLETION DATE
	with Section 9.7. Hospital outpatier required to be cla Health Care Occunumber of patient 19.1.3.3, 42 CFR Based on observatifailed to ensure 2 of 2 hour fire separative Living section of the care section of the when tested several openings required to for 1 1/2 hour in a 2 be protected by apprassemblies and fire accompanying hard closing devices, and accordance with the Standard for Fire D Protectives. 8.3.3.2 shall bear an appropriative could affect Findings include: Based on observation, and 2:30 p.m. the Director of Plar facility, the two set between the Assiste Care unit, which are hour fire walls that section and the skil facility did not late. Based on interview	ant surgical departments are saified as an Ambulatory apancy regardless of the s served. 482.41, 42 CFR 485.623 on and interview, the facility of 2 sets of fire doors in the two, on walls between the Assisted are facility and the skilled health facility closed fully and latched a times. LSC 8.3.3.1 states on have a fire protection rating hour fire wall or partition shall proved, listed, labeled fire door window assemblies and their alware, including all frames, chorage, and sills in the requirements of NFPA 80, thoors and Other Opening 2.2 states all products required aved label. This deficient et all residents. The one of 07/17/23 between 12:15 during a tour of the facility with ant Operations from a sister is of 90 minute rated fire doors and Living unit and the Skilled the part of the two separate, two separate the Assisted Living led health care section of the the when tested several times.	K 0131	The submission of this placorrection does not indicated admission by Thornton Telealth Campus that the findings and allegations contained herein are accutive representation of the quality of care provided, at the living environment provided to the residents Thornton Terrace Health Campus. The facility recognizes its obligation of provide legally and medicinecessary care and servicits residents in an economical and efficient manner. The facility hereby maintains is substantial compliance with state and federal requirem governing the management this facility. It is thus subtained as a matter of statute only facility respectfully request from the department a desireview for substantial compliance. Corrections to be completed 8/1/23	ate an errace arate, and of ally ces to nic c t is in ith all nents nt of mitted f. The sts sk

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Event ID:

U4QR21 Facility ID: 004075

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/09/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155734		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/17/2023			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 188 THORNTON RD HANOVER, IN 47243				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE	
	_	viewed with the Executive or of Plant Operations during		K131 Fire door not latching sto Assisted Living No residents were affected to alleged deficient practice. Skilled to Assisted Living doi immediately fixed. Director of Plant Operations audited skilled nursing fire dowith no further findings Director of Plant Operations educated on tag K131 As a measure of ongoing compliance, skilled fire doors be audited by Director of Plant Operations/Executive Director Designee once a week for two months then twice monthly from this. Findings and corrective action be reviewed and updated as warranted by the QAPI committee. The results of the audits will be reviewed by Quommittee overseen by the Executive Director if a thresh 100% is not achieved an act plan will be developed. The through the QAPI program wereview update and make chartor POC as needed for sustain substantial compliance.	oy this or oors s will int or or oor four on will dese A hold of ion facility vill anges		
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other						

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List in the REMARKS section any LSC

Event ID:

U4QR21

Facility ID: 004075

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` ′		(X2) MULTIPLE CONSTRUCTION (X3) DATE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155734	B. W	ING		07/17/	2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 188 THORNTON RD HANOVER, IN 47243			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERIC DLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NIE.	DATE
	provided K-tags, be information, along Safety Code or NF should be included 1. Based on observer facility failed to repalarms installed in a sleeping rooms in a NFPA 72, 2010 Editurbes otherwise recommunificaturer's publimultiple-station smowhen they fail to resishall not remain in a from the date of material practice could affect visitors. Findings include: Based on observation p.m. and 2:30 p.m. the Director of Plant facility brought in a operated smoke alar room battery operated manufactured dates least two resident real alarms had manufactor interview at the smoke alarms, the I confirmed most smoke alarms, the I confirmed most smoke alar of 05/2000 and were past due for real real finding was real through the smoke of 05/2000 and were past due for real real finding was real finding was real real finding was real	are not addressed by the but are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567. ation and interview, the blace battery operated smoke at least 15 of the 32 resident ecordance with NFPA 72. ation, Section 14.4.8.1 states commended by the black dished instructions, single- and ooke alarms shall be replaced spond to operability tests but service longer than 10 years mufacture. This deficient at all residents, staff and the performing record review, at Operations from a sister a several resident room battery rms. Most of the resident red smoke alarms had of 05/2000 or 12/2012. At from battery operated smoke ctured dates of 04/2015. Based time of observation of the Director of Plant Operations ooke alarms had manufactured at 12/2012 and agreed they replacement.	K 0	300	The submission of this plan correction does not indicate admission by Thornton Territhealth Campus that the findings and allegations contained herein are accurative 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 medicall necessary care and services its residents in an economic and efficient manner. The facility hereby maintains it is substantial compliance with state and federal requiremer governing the management this facility. It is thus submit as a matter of statute only. Facility respectfully requests from the department a desk review for substantial compliance. Corrections to be completed 8/1/23	an ace te, I s in all alts of tted The	08/01/2023

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Event ID:

U4QR21 Facility ID: 004075

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155734	B. W	B. WING			/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			ORNTON RD		
THORNI	TON TERRACE HE	ALTH CAMPLIS			/ER, IN 47243		
11101111	·	ALTITOAWI 00		TIANO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					K300: Failed to replace batter	У	
	3.1-19(b)				power smoke alarms within		
					10years of manufacture date.		
	2. Based on record review and interview, the				Battery replacement needs		
		sure documentation for the			documented annually		
	_	enance of battery operated					
		2 of 32 resident sleeping rooms					
	_	PA 72 14.2.1.1.1 states to ensure			No residents were affected by	this	
		, the system shall have an			alleged deficient practice		
		and maintenance program.			Smoke alarms identified		
		tes fire-warning equipment shall			immediately changed		
	be maintained and tested in accordance with				Smoke alarms audited and ful	rther	
	_	lished instructions and per the			findings replaced		
	_	apter 14. This deficient			Educated Director of Plant		
	1 -	et all residents, staff and			Operations on documentation		
	visitors.				showing battery replacement		
	F: 1: : 1 1				annually.		
	Findings include:				Further Director of Plant		
	D 1 1	. 07/17/221 4 0.15			Operations educated on chan		
		view on 07/17/23 between 9:15			smoke alarms every ten years	;	
	_	with the Director of Plant sister facility present, the			from manufacture's date		
	-	noke alarm maintenance			As a measure of ongoing	rmo	
	. –	ed to indicate battery			compliance, skilled smoke ala will be audited by Director of F		
		d on interview at the time of			Operations/Executive	-iaiii	
	_	Director of Plant Operations			Director/Designee once a wee	ak for	
		e if the batteries in the resident			two months then twice monthl		
		s had been replaced, but agreed			four months.	y 101	
		the preventative maintenance			Findings and corrective action	will	
	documentation.	Provention in minimum			be reviewed and updated as		
					warranted by the QAPI		
	This finding was re	eviewed with the Executive			committee. The results of the	se	
	_	tor of Plant Operations during			audits will be reviewed by QA		
	the exit conference	-			committee overseen by the		
					Executive Director if a thresho	old of	
	3.1-19(b)				100% is not achieved an action		
					plan will be developed. The fa	acility	
					through the QAPI program wil	-	
					review update and make char		
					to POC as needed for sustain	-	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE (A. BUILDING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
11.212.11		155734	B. WING	07/17/2023	
	PROVIDER OR SUPPLIER		188 T	STREET ADDRESS, CITY, STATE, ZIP COD 188 THORNTON RD HANOVER, IN 47243	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
mo	REGELATORT OF	ESC ISENTI TING INTONVITON	ind	substantial compliance.	DATE
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with Nappection, Testing Water-based Fire Records of system inspection and test secure location are a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any reautomatic sprinkle 9.7.5, 9.7.7, 9.7.8. Based on observation failed to ensure the smoke compartment sprinkler heads to firm this deficient pract residents, staff, and Findings include: Based on observation p.m. and 2:30 p.m. the Director of Plant facility, the sprinkle Office and storage in had escutcheon ring inches which left a secure of the security of the secu	supply source RKS information on non-required or partial er system. and NFPA 25 on and interview, the facility ceiling in 2 of 5 sprinklered ts was maintained to allow unction to their full capability. ice could affect at least 20	K 0353	The submission of this plan correction does not indicate admission by Thornton Terr Health Campus that the findings and allegations contained herein are accura 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 medicall necessary care and services its residents in an economic and efficient manner. The	e an race te, d

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

PRINTED: 08/09/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155734	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/17/2023	
	PROVIDER OR SUPPLIEI		188 TF	ADDRESS, CITY, STATE, ZIP C HORNTON RD VER, IN 47243	OD	
(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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) HOULD BE COMPLETION DATE	
	observation, the Di acknowledged the of down to low and cr around the sprinkle locations. This finding was re	at the time of each rector of Plant Operations escutcheon rings were hanging reated a one half inch gap repipe to the attic space at both eviewed with the Executive for of Plant Operations during		facility hereby mainta substantial compliant state and federal requ governing the manage this facility. It is thus as a matter of statute facility respectfully re from the department a review for substantial compliance. Corrections to be con 8/1/23	ce with all irements ement of submitted only. The quests a desk	
				No residents were affer alleged deficient practice. Sprinkler head escutch housekeeping office, so next to resident room 2 immediately fixed. Director of Plant Operations with no further find Director of Plant Operations with no further find Director of Plant Operations with no further find Director of Plant Operations and the secutcheon rings need affixed to the ceiling. As a measure of ongoing compliance, escutched be audited by Director Operations/Executive Industrial Designee once a week months then twice more months. Findings and corrective be reviewed and update warranted by the QAPI	ations escutcheon dings ations head to be ng on rings will of Plant Director or of for two highly for four e action will ded as	

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Event ID:

U4QR21 Facility ID: 004075

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPLETED		
		155734	B. W	ING		07/17/	/2023	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 188 THORNTON RD HANOVER, IN 47243					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					committee. The results of the audits will be reviewed by QA committee overseen by the Executive Director if a thresholon 100% is not achieved an actic plan will be developed. The f through the QAPI program will review update and make charto POC as needed for sustain substantial compliance.	old of on acility Ill nges		
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bu Barrier Doors 2012 EXISTING Doors in smoke b solid bonded wood construction that Nonrated protecti are permitted. Do fixed fire window are self-closing or require latching, a in the direction of provides a minim for swinging or ho 19.3.7.6, 19.3.7.8 Based on observati failed to ensure 1 of which swing in the with an astragal ha coordinator to ensu first always closes		K 0	374	The submission of this plan correction does not indicate admission by Thornton Terr Health Campus that the findings and allegations contained herein are accura true representation of the quality of care provided, and the living environment	e an race te,	08/01/2023	

FORM CMS-2567(02-99) Previous Versions Obsolete

Findings include:

Event ID:

U4QR21

Facility ID: 004075

provided to the residents of **Thornton Terrace Health**

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

PRINTED: 08/09/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155734	A. BUILDING B. WING	01	COMPLETED 07/17/2023
	PROVIDER OR SUPPLIER		188 TH	ADDRESS, CITY, STATE, ZIP COD IORNTON RD VER, IN 47243	
(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
	Based on observation p.m. and 2:30 p.m. of the Director of Plan facility, the set of sr. Living Room and the same direction when one of the doors. The attached to the door the doors did not close a six inch gap between interview at the time of Plant Operations doors did not close of the doo	during a tour of the facility with at Operations from a sister make barrier doors between the south service hall closed in with an astragal attached to there was a door coordinator frame, however, when tested, ose completely and there was seen the doors. Based on the of observation, the Director agreed the smoke barrier completely when tested. Wiewed with the Executive or of Plant Operations during		Campus. The facility recognizes its obligation to provide legally and medically necessary care and services its residents in an economic and efficient manner. The facility hereby maintains it is substantial compliance with state and federal requirement governing the management this facility. It is thus submit as a matter of statute only. If facility respectfully requests from the department a desk review for substantial compliance. Corrections to be completed by alleged deficient practice. Door coordinator identified fixed Director of Plant Operations audited door coordinators with further findings. Director of Plan Operations educated on door coordinator. As a measure of ongoing compliance, skilled smoke dowill be audited by Director of Poperations, Executive Director Designee once a week for two months then twice monthly for months. Findings and corrective action be reviewed and updated as warranted by the QAPI	y to sin all its of tted The Py r this ed n no ors Plant r or or or four

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

U4QR21 Facility ID: 004075

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155734	B. W	ING		07/17/	/2023
		l .		CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP COD 188 THORNTON RD				
THODNE	ON TERRACE HEA	ALTIL CAMPUS					
INORNI	ON TERRACE HEA	ALTH CAMPUS		HANO	/ER, IN 47243		
(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 BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					committee. The results of the	se	
					audits will be reviewed by QA		
					committee overseen by the		
					Executive Director if a thresho	ld of	
					100% is not achieved an actio	n	
					plan will be developed. The fa		
					through the QAPI program wil	-	
					review update and make chan		
					to POC as needed for sustaini	-	
					substantial compliance	3	
K 0511	NFPA 101						
SS=E	Utilities - Gas and	Electric					
Bldg. 01	Utilities - Gas and	Electric					
-	Equipment using	gas or related gas piping					
		PA 54, National Fuel Gas					
		riring and equipment					
		PA 70, National Electric					
		stallations can continue in					
	service provided r						
	18.5.1.1, 19.5.1.1						
		ration and interview, the	K 0	511	The submission of this plan	of	08/01/2023
		sure at least 11 of over 30 wet	120		correction does not indicate		00/01/2020
	locations, were pro-	vided with ground fault circuit			admission by Thornton Terra		
	_	protection against electric			Health Campus that the		
		NEC 2011 Edition at 210.8			findings and allegations		
		it-Interrupter Protection for			contained herein are accurat	e,	
		round-fault circuit-interruption			true representation of the	•	
	_	be provided as required in			quality of care provided, and		
	•	C). The ground-fault			the living environment		
		hall be installed in a readily			provided to the residents of		
	accessible location.	-			Thornton Terrace Health		
	Informational Notes	: See 215.9 for ground-fault			Campus. The facility		
		rotection for personnel on			recognizes its obligation to		
	feeders.	•			provide legally and medically	,	
		velling Units. All 125-volt,			necessary care and services		
	` '	nd 20-ampere receptacles			its residents in an economic		
		tions specified in 210.8(B)(1)			and efficient manner. The		

through (8) shall have ground-fault

facility hereby maintains it is in

PRINTED: 08/09/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155734	B. WI	NG		07/17	/2023
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			IORNTON RD		
THORN	TON TERRACE HE	ALTH CAMPUS		HANOVER, IN 47243			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	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)		DATE
	circuit-interrupter p	protection for personnel.			substantial compliance with	all	
	(1) Bathrooms				state and federal requiremer	nts	
	(2) Kitchens				governing the management	of	
	(3) Rooftops				this facility. It is thus submi	tted	
	(4) Outdoors				as a matter of statute only.	The	
	Exception No. 1 to	(3) and (4): Receptacles that are			facility respectfully requests		
	not readily accessib	ole and are supplied by a			from the department a desk		
	branch circuit dedic	cated to electric snow-melting,			review for substantial		
	deicing, or pipeline and vessel heating equipment				compliance.		
	U	to be installed in accordance			Corrections to be completed by	ΟV	
	with 426.28 or 427				8/1/23	,	
		(4): In industrial establishments			K511		
	_	nditions of maintenance and			No residents were affected by	this	
	1	that only qualified personnel			alleged deficient practice		
	_	sured equipment grounding			Ground fault outlets identified		
		as specified in 590.6(B)(2)			removed and replaced with pl	ate	
		for only those receptacle			coverings. Beauty shop outlet		
	_	ply equipment that would			rewired to function correctly		
		ard if power is interrupted or			Director of Plant Operations		
	_	at is not compatible with GFCI			audited outlets within six feet	of	
	protection.	it is not companie with Gr Cr			water source with no further	OI .	
	^	eceptacles are installed within					
		outside edge of the sink.			findings Director of Plan Operations		
	` ′	(5): In industrial laboratories,			Director of Plan Operations educated on outlets within six	foot	
	_	supply equipment where					
	^				of water source need to have	а	
	_	would introduce a greater			ground fault.		
	•	mitted to be installed without			As a measure of ongoing		
	GFCI protection.	(5) F			compliance outlets near water		
	*	(5): For receptacles located in			sources will be audited by Dire		
		ns of general care or critical			of Plant Operations, Executive		
		care facilities other than those			Director, Designee once a we		
	covered under				for two months then twice mon	nthly	
		protection shall not be required.			for four months.		
	(6) Indoor wet loca				Findings and corrective action	will	
	` '	vith associated showering			be reviewed and updated as		
	facilities				warranted by the QAPI		
		e bays, and similar areas where			committee. The results of the	se	
	electrical				audits will be reviewed by QA		

diagnostic equipment, electrical hand tools.

NFPA 70, 517-20 Wet Locations, requires all

committee overseen by the

Executive Director if a threshold of

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMP.			LETED		
155734		155734				07/17	/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ORNTON RD			
THODNITON TEDDACE HEALTH CAMPUS					/ER, IN 47243			
THORNTON TERRACE HEALTH CAMPUS				LIZINOV	LIN, IIN 47 240			
(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 BE CROSS-REFERENCED TO THE APPROPR		COMPLETION	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE	
	-	ed equipment within the area of			100% is not achieved an action			
		have ground-fault circuit			plan will be developed. The fa	-		
		protection. Note: Moisture can			through the QAPI program will review update and make changes			
		resistance of the body, and						
		is more subject to failure.		to POC as needed for sustaining		ing		
	-	cice could affect one resident			substantial compliance			
		auty Shop/Salon and over 10						
	_	gacy Lane section of the						
	facility.							
	Findings indude.							
	Findings include:							
	Rased on observation	ons on 07/17/23 between 12:15						
		during a tour of the facility with						
		nt Operations from a sister						
	facility, the following	-						
	-	p/Salon had a GFCI receptacle						
		he hair washing sink. When						
		tester it appeared the						
		ed correctly, however, when						
	-	button on the testing device						
		t was not broken. Even when						
	testing the test button on the receptacle, the electrical circuit was not broken. This was acknowledged by the Director of Plant Operations							
	at the time of observation.							
	b. 10 of 10 resident rooms in the Legacy Lane unit							
	had electrical receptacles within four feet of each							
	room sink. These r	receptacles were not provided						
	with GFCI protection	on. This was confirmed when						
	-	I testing device. This was						
		he Director of Plant Operations						
	at the time of each	observation.						
	_	viewed with the Executive						
	Director and Director of Plant Operations during the exit conference.							
	3.1-19(b)							
			1				1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155734		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/17/2023	
NAME OF PROVIDER OR SUPPLIER THORNTON TERRACE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP COD 188 THORNTON RD HANOVER, IN 47243					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 0711	facility failed to east the Housekeeping Cover plate and was NFPA 70, 2011 Edi Faceplates (Cover If faceplates shall be in cover the opening a surface. NFPA 70, 2012 Exposed Terminals so that live wiring the contact. This deficit least one staff while Findings include: Based on observation p.m. and 2:30 p.m. the Director of Plant facility, the Housek electrical receptacles a cover plate. A sminto this receptacles into this receptacles time of observation Operations acknow on the electrical reconfice. This finding was re Director and Direct the exit conference.	ation and interview, the sure 1 electrical receptacle in Office was provided with a protected from damage. Ition. Article 406.6, Receptacle Plates), requires receptacle installed so as to completely and seat against the mounting 2011 Edition. Article 406.5 (F), Receptacles shall be enclosed erminals are not exposed to ent practice could affect at e in the Housekeeping Office. Ons on 07/17/23 between 12:15 during a tour of the facility with at Operations from a sister reeping Office had one e on the wall not provided with hall refrigerator was plugged Based on interview at the the Director of Plant ledged the lack of a cover plate reptacle in the Housekeeping viewed with the Executive or of Plant Operations during					
K 0711 SS=F Bldg. 01		elocation Plan plan for the protection of all eir evacuation in the event					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155734		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/17/2023		
NAME OF PROVIDER OR SUPPLIER THORNTON TERRACE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP COD 188 THORNTON RD HANOVER, IN 47243				
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	kept informed with and a copy of the with telephone opplan addresses the of staff per 18/19. of the fire safety per 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3, 19.7.2.1.2, 19.7.2. Based on record revergialed to provide a converted with the safety per 38 residents to accust systems, plus a system required by NFPA 19.7.2.2. LSC 19.7 occupancy fire safethe following: (1) Use of alarms (2) Transmission of (3) Emergency phorough (4) Response to alar (5) Isolation of fire (6) Evacuation of in (7) Evacuation of sin (8) Preparation of fire vacuation (9) Extinguishment Section 19.2.3.4(4) corridor shall not be width where serving patient sleeping roor required width shall equipment provided equipment during a addressed in the write stage of the safety	riew and interview, the facility complete facility specific lan for the protection of 38 of rately address all life safety em addressing all items 101, 2012 edition, Section .2.2 requires a written health care ty plan that shall provide for alarm to fire department each compartment corns and building for of fire states any required aisle or eless than 48 inches in clear g as means of egress from ms. Projections into the libe permitted for wheeled the relocation of wheeled fire or similar emergency is itten fire safety plan and rithe facility. The wheeled	K 0711	The submission of this plan correction does not indicate admission by Thornton Terr Health Campus that the findings and allegations contained herein are accuratrue 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 medical necessary care and service its residents in an economic and efficient manner. The facility hereby maintains it is substantial compliance with state and federal requireme governing the management this facility. It is thus subm as a matter of statute only, facility respectfully requests from the department a desk review for substantial compliance. Corrections to be completed 8/1/23	e an race ate, d ly s to c s in n all nts of itted The s	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEDS FOR MEDICADE & MEDICAD SERVICES

PRINTED: 08/09/2023 FORM APPROVED OMB NO. 0938-039

ENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039									
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 01		01	COMPL	ETED		
		155734	B. WING			07/17/	2023		
					-				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD				
NAME OF TROVIDER OR SOFT EIER					ORNTON RD				
THORNT	ON TERRACE HE	ALTH CAMPUS		HANO\	/ER, IN 47243				
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	i. Equipment in use	and carts in use			K711: Plan does not address	staff			
	ii. Medical emerger	ncy equipment not in use			response to battery powered				
	iii. Patient lift and t	ransport equipment			smoke alarms located in resid	ent			
	This deficient pract	ice could affect all occupants			sleeping room.				
	in the event of an er	_			' "				
					No residents were affected by	this			
	Findings include:				alleged deficient practice				
	J				Battery power smoke alarm plan				
	Based on a review of	of the facility's "Fire			added to EOP				
	Emergency" plan on 07/17/23 between 9:15 a.m.				Staff educated on response to				
					battery power smoke alarm signal				
	and 12:15 p.m. with the Director of Plant Operations from a sister facility present, the plan				Director of plant				
	did not address staff response to battery powered				operation/Executive Director or				
					Designee audit three staff	"			
	smoke alarms located in resident sleeping rooms.				members on response to alarm of				
	Based on interview at the time of record review,				battery powered smoke alarms in				
	the Director of Plant Operations acknowledged				resident rooms once a week for				
	and agreed that the Fire Emergency plan did not				two months then twice monthly for				
	address staff response to battery powered smoke				four months.				
	alarms located in resident sleeping rooms.								
	Tl.:- C J'	and a control of the			Findings and corrective action	WIII			
	-	viewed with the Executive			be reviewed and updated as				
		or of Plant Operations during			warranted by the QAPI	ļ			
	the exit conference.				committee. The results of the				
					audits will be reviewed by QA				
	3.1-19(b)				committee overseen by the				
					Executive Director if a thresho				
					100% is not achieved an actio				
					plan will be developed. The fa	-			
					through the QAPI program wil	1			
					review update and make chan	iges			
					to POC as needed for sustain	ing			
					substantial compliance	ļ			
					·	ļ			