STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING **01** B. WING _____	**05/20/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 000	INITIAL COMMENTS A Pre-Occupancy 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: 05/20/25 Facility Number: 004075 Provider Number: 155734 AIM Number: 200491220 At this Pre-Occupancy Life Safety Code survey, Thornton Terrace Health Campus was found 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. The scope of pre-occupancy survey included a Remodel of Day Room in 220 Wing to create storage room. Remodeling of Nurse Station in 200Wing. Remodeling of counters in resident rooms in 200 Wing. General renovations to PT gym. 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 55 and had a census of 53 at the time of this visit.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING **01** B. WING _____	**05/20/2025**

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K 000	Continued From page 1 All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 05/22/25	K 000		