

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

PRINTED: 05/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155734		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2025	
NAME OF PROVIDER OR SUPPLIER THORNTON TERRACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>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).</p> <p>Survey Date: 05/20/25</p> <p>Facility Number: 004075 Provider Number: 155734 AIM Number: 200491220</p> <p>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.</p> <p>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.</p> <p>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.</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 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			