CENTERS 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. BU	JILDING	<u></u>	COMPLETED 08/13/2024	
		155789	B. WI	ING			
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
DIDCEM		ADUE			AMPUS DR		
RIDGEN	OOD HEALTH CAN	WIPUS		LAWK	ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
	An Emergency Pre	paredness Survey was	E 00	000	We would like to respectively		
	conducted by the In	diana Department of Health in			request a Desk Review in lieu	ı of a	
	accordance with 42	CFR 483.73.			Post Survey Revisit. We are		
					including all supporting		
	Survey Date: 08/13	3/2024			documentation as evidence the	nat	
					the deficiencies have been		
	Facility Number: 0	12523			corrected and we have a system		
	Provider Number:				in place to monitor and assur-		
	AIM Number: 201	027870			that we do not have a		
					reoccurrence of the deficience	ies	
	At this Emergency	Preparedness survey,			noted.		
		Campus was found in					
	_	mergency Preparedness			We appreciate your considera	ation	
	_	Medicare and Medicaid			in this matter. Please reach of		
	_	ders and Suppliers, 42 CFR			you need any additional pape		
	483.73.	**			to support our request our nu		
					is 812-537-5700.		
	The facility has 71	certified beds. At the time of					
	the survey, the cens				Thank you for all you do to as	sure	
					that we all have a safe		
	Quality Review cor	mpleted on 08/16/24			environment for our residents	; <u>.</u>	
		•			employees and visitors.	,	
					' '		
					Theresa Adams, HFA		
					Executive Director		
K 0000							
Bldg. 01							
=	A Life Safety Code	Recertification and State	K 0	000	We would like to respectively		
	-	vas conducted by the Indiana	12 0		request a Desk Review in lieu		
		Ith in accordance with 42 CFR			Post Survey Revisit. We are		
	483.90(a).				including all supporting		
					documentation as evidence the	nat	
	Survey Date: 08/13	/2024			the deficiencies have been		

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

Facility Number: 012523

TITLE

corrected and we have a system

in place to monitor and assure

(X6) DATE

Theresa Adams Executive Director 08/29/2024

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: 1PJ521 Facility ID: 012523 If continuation sheet Page 1 of 11

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

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155789		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 08/13/2024	
	ROVIDER OR SUPPLIER		181 C	ADDRESS, CITY, STATE, ZIP COD AMPUS DR ENCEBURG, IN 47025	•
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE DATE
	Provider Number: AIM Number: 201			that we do not have a reoccurrence of the deficienc noted.	ies
	Health Campus was	Code survey, Ridgewood found not in compliance with		We appreciate your consider	
	Requirements for Parameter Reducate Reducate Reducate Reducate Reducate Reducate Reducate Requirements for Parameter Reducate Red	articipation in , 42 CFR Subpart 483.90(a),		in this matter. Please reach or you need any additional paper	
	National Fire Protect	re and the 2012 Edition of the etion Association (NFPA) 101,		to support our request our nu is 812-537-5700.	mber
		SC), Chapter 19, Existing ancies and 410 IAC 16.2.		Thank you for all you do to as that we all have a safe	ssure
	Ridgewood Health Campus consists of two separate buildings. The Main Campus, Building 01, is a one story building and was determined to			environment for our residents employees and visitors.	·,
	be of Type V (111)	construction and fully egacy Building, Building 02,		Theresa Adams, HFA Executive Director	
	building was detern	east of the Main Campus nined to be of Type V (111)			
	have a fire alarm sy	lly sprinklered. Both buildings stem with smoke detection in			
	has smoke detectors	areas open to the corridor and shard wired to the fire alarm			
		nt sleeping rooms. The facility and had a census of 66 at the			
		dents have customary access d all areas providing facility clered.			
	Quality Review con	npleted on 08/16/24			
K 0222 SS=E Bldg. 01	be equipped with	d means of egress shall not a latch or a lock that f a tool or key from the			
	egress side unless	s using one of the following			

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Facility ID: 012523

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	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155789	(X2) MULTIPLE ( A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/13/2024
	OF PROVIDER OR SUPPLIE EWOOD HEALTH CAI		181 C	ADDRESS, CITY, STATE, ZIP COD AMPUS DR ENCEBURG, IN 47025	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.	LD BE COMPLETION
PREFIX TAG	special locking and CLINICAL NEEDS LOCKING Where special locking and used, only one lock permitted on each be made for the raby: remote control locks or keys carrother such reliable staff at all times.  18.2.2.2.5.1, 18.2.  19.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special lock safety needs of the the Clinical or Section are being met. In electrical locks that release upon loss building is protect automatic sprinkle space is protected detection system at an attended lock space); and both systems are arrar upon activation.  18.2.2.2.5.2, 19.2. DELAYED-EGRE ARRANGEMENT Approved, listed of systems installed 7.2.1.6.1 shall be assemblies serving contents in building an approved, sup	rangements: S OR SECURITY THREAT  cking arrangements for the eds of the patient are cking device shall be a door and provisions shall apid removal of occupants. I of locks; keying of all ited by staff at all times; or e means available to the care patient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised er system and the locked draw and the locked the sprinkler and detection aged to unlock the doors.	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	DBE COMPLETION
	I	•	ı	I	1

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STATEMEN	T OF DEFICIENCIES	OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) !		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN		01	COMPL	LETED	
		155789	B. WI	B. WING		08/13	/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	₹			MPUS DR			
RIDGEW	OOD HEALTH CAN	MPUS			ENCEBURG, IN 47025			
INDOLW				L/WVINL			•	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE	
	automatic sprinkle	-						
	18.2.2.2.4, 19.2.2							
	ACCESS-CONTR							
	LOCKING ARRAN							
		d Egress Door assemblies						
		lance with 7.2.1.6.2 shall						
	be permitted.	2.4						
	18.2.2.2.4, 19.2.2	.2.4 BY EXIT ACCESS						
	LOCKING ARRAN							
		t access door locking in						
		7.2.1.6.3 shall be permitted						
		es in buildings protected						
		approved, supervised					1	
		ection system and an						
		ised automatic sprinkler						
	system.						1	
	18.2.2.2.4, 19.2.2	.2.4						
		on and interview, the facility	K 0	222	Immediate intervention		08/26/2024	
	failed to ensure 1 of	f 2 main courtyard egress			The Director of Plant Operatio	ns		
	doors was free of al	l obstructions or impediments			removed the gate drop rod fro			
		the case of fire or other			the second door so when the	mag		
		dance with LSC 7.1.10.1. This			lock drops both doors can be			
	_	ould affect all staff, residents,			opened with one motion. (Exh	ibit		
	and visitors				L)			
					The Director of Plant Operatio			
	Findings include:				was educated by the Executiv			
					Director on K222- Egress Doo	rs.		
		on during a tour of the facility			(See Attached Exhibit A)		1	
		veen 1:45 PM and 4:15 PM with			Doors in a required means of	•••		
		at Operations and Maintenance			egress shall not be equipped			
		doors in the main courtyard			a latch or a lock that requires	ine		
		ors. 1 of 2 doors was equipped			use of a tool or key from the	_ £	1	
		d on the outside of the door			egress side unless using one	Oĭ		
	1 -	door from being able to be			the following special locking		1	
	_	side and prevents the door			arrangements: 18.2.2.2.5.1,			
		be opened with one motion.  at the time of observation, the			18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6			
		perations and Maintenance				n will		
		gate drop rod was present on			The Director of Plant Operation inspect the deficient egress do			
1	i pappori agreeu ille	gate arop rou was present on	1		, mapeut the delibitifit tults du	JUI 5	ì	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155789	B. WI	NG		08/13/	/2024
		<u> </u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t .			MPUS DR		
RIDGEW	OOD HEALTH CAN	MPUS		LAWRE	ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the door.				for compliance 1 x week for 1		
	Th: - C. 1:	i			month and 1 x a month for 3	4 D)	
	_	viewed with the Director of			months. (See Attached Exhibit	(B)	
	-	faintenance Support, Executive tor of Health Services at the			="" p="">	an .	
	exit conference.	tor of Health Services at the			Results of these inspections was be presented by Executive	ЛП	
	exit conference.				Director to the QA committee	for	
	3.1-19(b)				further recommendations and	OI	
	3.1-17(0)				continue until the Quality		
					Assurance Team determines		
					substantial compliance has be	en	
					achieved.	•	
					The deficient practice could af	fect	
					all staff, residents and visitors.		
					,		
K 0293	NFPA 101						
SS=E	Exit Signage						
Bldg. 01	Exit Signage						
	2012 EXISTING						
		al signs are displayed in					
		'.10 with continuous					
		erved by the emergency					
	lighting system.						
	19.2.10.1						
	(Indicate N/A in or	-					
	-	less than 30 occupants					
		exit travel is obvious.) on and interview; the facility	V O	202	Immediate Intervention		08/26/2024
		signage in 1 of 1 main	K 02	293	The Director of Plant Operation	ne	08/26/2024
		dance with LSC 7.10. LSC			installed 2 directional exit sign		
	-	er than main exterior exit doors			the courtyard that lead in the	3 111	
		clearly are identifiable as exits,			direction of the exit gate and a	ın	
		an approved sign that is			exit sign on the gate. (See		
		any direction of exit access.			Exhibits G, H, I)		
		es horizontal components of the			The Director of Plant Operatio	ns	
		in exit enclosure shall be			was educated by the Executiv		
		d exit or directional exit signs			Director on K293- Exit Signage		
		ion of the egress path is not			(See Exhibit A)		
		ient practice could affect staff			Exits, other than main exterior	exit	
	and at least 10 resid				doors that obviously and clear		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155789	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/13/2024
	PROVIDER OR SUPPLIER		181 CA	ADDRESS, CITY, STATE, ZIP COD AMPUS DR ENCEBURG, IN 47025	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Operations and Mai tour of the facility of and 4:15 PM, the main skilled/health side of assisted living area alabeled as emergence located on the far er skilled/health side exit gate was blocked including a tree. No exit gate was located courtyard.  This finding was revelent plant Operations, Main and American State of the facility of the plant of the facility of the plant of the facility of the	on with the Director of Plant Intenance Support during a in 08/13/2024 between 1:45 PM ain courtyard had 4 doors courtyard (1 of 4 in the fif the building and 3 of 4 in the of the building) which were by exits. The exit gate was and of the courtyard from the interest was also from view by landscaping, signage indicating where the did was observed in the viewed with the Director of faintenance Support, Executive for of Health Services at the		are identifiable as exits, shall marked by an approved sign is readily visible from any dire of exit access.  The Director of Plant Operati inspect the deficient exit sign for compliance 1 x week for 1 month and 1 x a month for 3 months. (See Exhibit B)  Results of these inspections be presented by Executive Director to the QA committee further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved.  The deficient practice could a staff and at least 10 residents	that ection on will age will for d een
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dr and unexpected til conditions, at leas The staff is familia aware that drills al routine. Where dr 9:00 PM and 6:00	t quarterly on each shift.  r with procedures and is re part of established  ills are conducted between  AM, a coded  ay be used instead of			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155789		(X2) MULTIPL A. BUILDING B. WING	LE CONSTRUCTION  G  01	(X3) DATE SURVEY COMPLETED 08/13/2024	
	PROVIDER OR SUPPLIER		181	EET ADDRESS, CITY, STATE, ZIP COD CAMPUS DR WRENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION DATE
	failed to conduct 3rd of 4 quarters. LSC 1 conducted quarterly conditions. This defand residents.  Findings include:  Based on record revious AM and 1:45 Operations and Maid documentation for a quarter of 2024 was interview at the time of Plant Operations regarding the time the facility.  This finding was revious Plant Operations, Maid of the facility of the facil	riew and interview, the facility d shift quarterly fire drills for 1 19.7.1.6 requires drills to be on each shift under varied ficient practice affects all staff riew on 08/13/2024 between PM with the Director of Plant Internance Support, no a 3rd shift fire drill for the first available for review. Based on the of record review, the Director stated he got confused third shift started at this wiewed with the Director of Iaintenance Support, Executive tor of Health Services at the	K 0712	Immediate Intervention The Director of Plant Opera conducted a 3rd shift fire di (See Exhibits C,D,E,F) The Director of Plant Opera was educated by the Exect Director on K712- Fire Drill Exhibit A) Fire drills include the transi of a fire alarm signal and simulation of emergency fir conditions. Fire drills are he expected and unexpected i under varying conditions, a quarterly on each shift. The familiar with procedures an aware that drills are part of established routine. Where are conducted between 9:0 and 6:00 AM, a coded announcement may be use instead of audible alarms. The Director of Plant Opera inspect for Fire Drill complix x week for 1 month and 1 x month for 3 months. (See E B) Results of these inspection be presented by Executive Director to the QA committe further recommendations a continue until the Quality Assurance Team determine substantial compliance has achieved. The deficient practice affect staff, residents and visitors	rill. ations ative s. (See mission e eld at imes t least e staff is d is drills 0 PM ad ation will ance 1 a Exhibit s will ee for nd es been
K 0000					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) I		(X3) DATE	SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>02</u>		COMPL	ETED
		155789	B. WI	NG		08/13/	2024
				CED FEE	A DODDEGG CHTM CTATE THE COD		
NAME OF P	ROVIDER OR SUPPLIER	_			ADDRESS, CITY, STATE, ZIP COD		
DIDOEW		ADUG			MPUS DR		
RIDGEW	OOD HEALTH CAN	/IPUS		LAWRE	ENCEBURG, IN 47025		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 02							
	A Life Safety Code	Recertification and State	K 0	000	We would like to respectively		
	•	as conducted by the Indiana		300	request a Desk Review in lieu	of a	
		th in accordance with 42 CFR			Post Survey Revisit. We are		
	483.90(a).				including all supporting		
	()				documentation as evidence the	at	
	Survey Date: 08/13/	/2024			the deficiencies have been		
					corrected and we have a syste	-m	
	Facility Number: 0	12523			in place to monitor and assure		
	Provider Number:				that we do not have a		
	AIM Number: 2010				reoccurrence of the deficiencie	26	
	THINT I VAINIOUT. 2010	327070			noted.	,3	
	At this Life Safety (	Code survey, Ridgewood			noted.		
		found not in compliance with			We appreciate your considera	tion	
	Requirements for Pa	_			in this matter. Please reach or		
	-	, 42 CFR Subpart 483.90(a),			you need any additional paper		
		re and the 2012 Edition of the			to support our request our nun		
	-	etion Association (NFPA) 101,			is 812-537-5700.	ibei	
		SC), Chapter 19, Existing			13 0 12-337-37 00.		
	•	ancies and 410 IAC 16.2.			Thank you for all you do to ass	SUITA	
	ricarin care occupi	ancies and 110 1110 10.2.			that we all have a safe	Suic	
	Ridgewood Health (	Campus consists of two			environment for our residents,		
	-	The Main Campus, Building			employees and visitors.		
		ailding and was determined to			employees and visitors.		
	•	construction and fully			Theresa Adams, HFA		
		egacy Building, Building 02,			Executive Director		
	-	east of the Main Campus			Executive Director		
		nined to be of Type V (111)					
	•	ly sprinklered. Both buildings					
		stem with smoke detection in					
	•	areas open to the corridor and					
		-					
		s hard wired to the fire alarm					
		nt sleeping rooms. The facility					
		and had a census of 66 at the					
	time of this survey.						
	A 11 1	1					
		dents have customary access					
		d all areas providing facility					
	services were sprink	kierea.					
			1		1		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155789	(X2) MULTIPLE ( A. BUILDING B. WING	O2	(X3) DATE SURVEY COMPLETED 08/13/2024
	PROVIDER OR SUPPLIER		181 C	ADDRESS, CITY, STATE, ZIP COD AMPUS DR RENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION INPleted on 08/16/24	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=E Bldg. 02	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of syster inspection and tes secure location ar a) Date sprinkler  b) Who provided  c) Water system  Provide in REMAI coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observation failed to maintain the mechanical rooms a outside room 613. N 3.3.5.4 defines a sn ceiling free from si indentations. The coaround the sprinkle operate at a specific 8.5.4.1.1 states the deflector and the coa based on the type o construction. This	supply source  RKS information on non-required or partial er system.  In and NFPA 25 on and interview, the facility ne ceiling construction in 1 of 1 and 1 of 1 areas near the camera NFPA 13, 2010 edition, Section nooth ceiling as a continuous gnificant irregularities, lumps, or ceiling traps hot air and gases or and causes the sprinkler to ed temperature. Section distance between the sprinkler ceiling above shall be selected of sprinkler and the type of deficient practice could affect up to 3 residents in the vicinity	K 0353	Immediate Intervention The Director of Plant Operation patched the drywall ceiling withe 2 inch gap that was located the mechanical room behind dryers. The Director of Plant Operations also removed the camera that was located outs room 613 and replaced the diceiling tile with a new one eliminating the penetration. (Sexhibits J & K) The Director of Plant Operation was educated by the Executival Director on K353- Sprinkler System- Maintenance and Testing. (See Exhibit A)	eth ed in the side rop see

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Event ID:

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Facility ID: 012523

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155789	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 08/13/2024
	PROVIDER OR SUPPLIER		181 CA	ADDRESS, CITY, STATE, ZIP COD AMPUS DR ENCEBURG, IN 47025	
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE
	on 08/13/2024 between the Director of Plan Support, a 2 inch per ceiling of the mechat behind the dryers in penetration of 1/4 in around the camera of interview at the time of Plant Operations agreed there were paraforementioned local measurements.  This finding was revenue.	on during a tour of the facility teen 1:45 PM and 4:15 PM with t Operations and Maintenance the traction was located in the anical room that leads to the Legacy building and a the was located in the ceiling toutside room 613. Based on the of observation, the Director and Maintenance Support tenetrations in the ations and provided the  wiewed with the Director of taintenance Support, Executive tor of Health Services at the		NFPA 13, 2010 edition, Sec 3.3.5.4 defines a smooth ce as a continuous ceiling free significant irregularities, lum indentations. The ceiling trajair and gases around the sp and causes the sprinkler to operate at a specified temperature.  The Director of Plant Operatinspect the areas of the penetrations for compliance week for 1 month and 1 x a for 3 months. (See Exhibit B Results of these inspections be presented by Executive Director to the QA committe further recommendations and continue until the Quality Assurance Team determines substantial compliance has achieved.  The deficient practice could staff, visitors and up to 3 resin the vicinity of those smoke compartments.	iling from ps, or ps hot rinkler  tion will  1 x month ) will e for d s been affect sidents
K 0712 SS=F Bldg. 02	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills at routine. Where dr 9:00 PM and 6:00	t quarterly on each shift. r with procedures and is re part of established ills are conducted between			

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155789		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>02</u>	(X3) DATE SURVEY COMPLETED 08/13/2024	
	PROVIDER OR SUPPLIER		181 CA	ADDRESS, CITY, STATE, ZIP COD AMPUS DR ENCEBURG, IN 47025	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	failed to conduct 3r of 4 quarters. LSC 1 conducted quarterly conditions. This def and residents.  Findings include:  Based on record rev 10:30 AM and 1:45 Operations and Mai documentation for a quarter of 2024 was interview at the tim of Plant Operations regarding the time t facility.  This finding was re Plant Operations, Mainterview at the time to facility.	9.7.1.7 riew and interview, the facility d shift quarterly fire drills for 1 19.7.1.6 requires drills to be on each shift under varied ficient practice affects all staff riew on 08/13/2024 between PM with the Director of Plant Internance Support, no a 3rd shift fire drill for the first available for review. Based on the of record review, the Director stated he got confused third shift started at this wiewed with the Director of Italiantenance Support, Executive for of Health Services at the	K 0712	Immediate Intervention The Director of Plant Operation conducted a 3rd shift fire drill. (See Exhibits C,D,E,F) The Director of Plant Operation was educated by the Executive Director on K712- Fire Drills. Exhibit A) Fire drills include the transmiss of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held expected and unexpected time under varying conditions, at lequarterly on each shift. The strainliar with procedures and it aware that drills are part of established routine. Where drare conducted between 9:00 and 6:00 AM, a coded announcement may be used instead of audible alarms. The Director of Plant Operation inspect for Fire Drill compliant x week for 1 month and 1 x a month for 3 months. (See Exh B) Results of these inspections where the presented by Executive Director to the QA committee further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved. The deficient practice affects staff, residents and visitors	ons ve (See esion  at es east taff is s ills PM  on will ce 1 hibit vill for

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