STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING -- B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/13/2024 Facility Number: 012523 Provider Number: 155789 AIM Number: 201027870 At this Emergency Preparedness survey, Ridgewood Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 71 certified beds. At the time of the survey, the census was 66. Quality Review completed on 08/16/24	E 0000	We would like to respectively request a Desk Review in lieu of a Post Survey Revisit. We are including all supporting documentation as evidence that the deficiencies have been corrected and we have a system in place to monitor and assure that we do not have a reoccurrence of the deficiencies noted. We appreciate your consideration in this matter. Please reach out if you need any additional paperwork to support our request our number is 812-537-5700. Thank you for all you do to assure that we all have a safe environment for our residents, employees and visitors. Theresa Adams, HFA Executive Director	
K 0000 Bldg. 01	A 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: 08/13/2024 Facility Number: 012523	K 0000	We would like to respectively request a Desk Review in lieu of a Post Survey Revisit. We are including all supporting documentation as evidence that the deficiencies have been corrected and we have a system in place to monitor and assure	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Theresa Adams	Executive Director	08/29/2024

Any defiencystatement 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 01 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Provider Number: 155789 AIM Number: 201027870 At this Life Safety Code survey, Ridgewood Health Campus was found not 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. Ridgewood Health Campus consists of two separate buildings. The Main Campus, Building 01, is a one story building and was determined to be of Type V (111) construction and fully sprinklered. The Legacy Building, Building 02, located to the southeast of the Main Campus building was determined to be of Type V (111) construction and fully sprinklered. Both buildings have a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 71 and had a census of 66 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/16/24		that we do not have a reoccurrence of the deficiencies noted. We appreciate your consideration in this matter. Please reach out if you need any additional paperwork to support our request our number is 812-537-5700. Thank you for all you do to assure that we all have a safe environment for our residents, employees and visitors. Theresa Adams, HFA Executive Director	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 01 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

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	special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised			

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	155789	A. BUILDING 01 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

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	automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure 1 of 2 main courtyard egress doors was free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. This deficient practice could affect all staff, residents, and visitors Findings include: Based on observation during a tour of the facility on 08/13/2024 between 1:45 PM and 4:15 PM with the Director of Plant Operations and Maintenance Support, the egress doors in the main courtyard had 2 swinging doors. 1 of 2 doors was equipped with a gate drop rod on the outside of the door which prevents the door from being able to be opened from the inside and prevents the door from being able to be opened with one motion. Based on interview at the time of observation, the Director of Plant Operations and Maintenance Support agreed the gate drop rod was present on	K 0222	Immediate intervention The Director of Plant Operations removed the gate drop rod from the second door so when the mag lock drops both doors can be opened with one motion. (Exhibit L) The Director of Plant Operations was educated by the Executive Director on K222- Egress Doors. (See Attached Exhibit A) Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 The Director of Plant Operation will inspect the deficient egress doors	08/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 01 B. WING	08/13/2024

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	the door. This finding was reviewed with the Director of Plant Operations, Maintenance Support, Executive Director, and Director of Health Services at the exit conference. 3.1-19(b)		for compliance 1 x week for 1 month and 1 x a month for 3 months. (See Attached Exhibit B) ="" p="">Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect all staff, residents and visitors.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview; the facility failed to install exit signage in 1 of 1 main courtyards in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect staff and at least 10 residents.	K 0293	Immediate Intervention The Director of Plant Operations installed 2 directional exit signs in the courtyard that lead in the direction of the exit gate and an exit sign on the gate. (See Exhibits G, H, I) The Director of Plant Operations was educated by the Executive Director on K293- Exit Signage (See Exhibit A) Exits, other than main exterior exit doors that obviously and clearly	08/26/2024

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	Findings include: Based on observation with the Director of Plant Operations and Maintenance Support during a tour of the facility on 08/13/2024 between 1:45 PM and 4:15 PM, the main courtyard had 4 doors leading to the main courtyard (1 of 4 in the skilled/health side of the building and 3 of 4 in the assisted living area of the building) which were labeled as emergency exits. The exit gate was located on the far end of the courtyard from the skilled/health side emergency exit door and the exit gate was blocked from view by landscaping, including a tree. No signage indicating where the exit gate was located was observed in the courtyard. This finding was reviewed with the Director of Plant Operations, Maintenance Support, Executive Director, and Director of Health Services at the exit conference. 3.1-19(b)		are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. The Director of Plant Operation will inspect the deficient exit signage for compliance 1 x week for 1 month and 1 x a month for 3 months. (See Exhibit B) Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect staff and at least 10 residents.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7			

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	155789	A. BUILDING 01 B. WING	08/13/2024

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	Based on record review and interview, the facility failed to conduct 3rd shift quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review on 08/13/2024 between 10:30 AM and 1:45 PM with the Director of Plant Operations and Maintenance Support, no documentation for a 3rd shift fire drill for the first quarter of 2024 was available for review. Based on interview at the time of record review, the Director of Plant Operations stated he got confused regarding the time third shift started at this facility. This finding was reviewed with the Director of Plant Operations, Maintenance Support, Executive Director, and Director of Health Services at the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	Immediate Intervention The Director of Plant Operations conducted a 3rd shift fire drill. (See Exhibits C,D,E,F) The Director of Plant Operations was educated by the Executive Director on K712- Fire Drills. (See Exhibit A) Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. The Director of Plant Operation will inspect for Fire Drill compliance 1 x week for 1 month and 1 x a month for 3 months. (See Exhibit B) Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice affects all staff, residents and visitors	08/15/2024
K 0000				

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	155789	A. BUILDING 02 B. WING	08/13/2024

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RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

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Bldg. 02	A 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: 08/13/2024 Facility Number: 012523 Provider Number: 155789 AIM Number: 201027870 At this Life Safety Code survey, Ridgewood Health Campus was found not 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. Ridgewood Health Campus consists of two separate buildings. The Main Campus, Building 01, is a one story building and was determined to be of Type V (111) construction and fully sprinklered. The Legacy Building, Building 02, located to the southeast of the Main Campus building was determined to be of Type V (111) construction and fully sprinklered. Both buildings have a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 71 and had a census of 66 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.	K 0000	We would like to respectively request a Desk Review in lieu of a Post Survey Revisit. We are including all supporting documentation as evidence that the deficiencies have been corrected and we have a system in place to monitor and assure that we do not have a reoccurrence of the deficiencies noted. We appreciate your consideration in this matter. Please reach out if you need any additional paperwork to support our request our number is 812-537-5700. Thank you for all you do to assure that we all have a safe environment for our residents, employees and visitors. Theresa Adams, HFA Executive Director	

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	155789	A. BUILDING 02 B. WING	08/13/2024

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	Quality Review completed on 08/16/24			
K 0353 SS=E Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 mechanical rooms and 1 of 1 areas near the camera outside room 613. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff, visitors, and up to 3 residents in the vicinity of those smoke compartments. Findings include:	K 0353	Immediate Intervention The Director of Plant Operations patched the drywall ceiling with the 2 inch gap that was located in the mechanical room behind the dryers. The Director of Plant Operations also removed the camera that was located outside room 613 and replaced the drop ceiling tile with a new one eliminating the penetration.(See Exhibits J & K) The Director of Plant Operations was educated by the Executive Director on K353- Sprinkler System- Maintenance and Testing. (See Exhibit A)	08/21/2024

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	Based on observation during a tour of the facility on 08/13/2024 between 1:45 PM and 4:15 PM with the Director of Plant Operations and Maintenance Support, a 2 inch penetration was located in the ceiling of the mechanical room that leads to behind the dryers in the Legacy building and a penetration of 1/4 inch was located in the ceiling around the camera outside room 613. Based on interview at the time of observation, the Director of Plant Operations and Maintenance Support agreed there were penetrations in the aforementioned locations and provided the measurements. This finding was reviewed with the Director of Plant Operations, Maintenance Support, Executive Director, and Director of Health Services at the exit conference. 3.1-19(b)		NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. The Director of Plant Operation will inspect the areas of the penetrations for compliance 1 x week for 1 month and 1 x a month for 3 months. (See Exhibit B) Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect staff, visitors and up to 3 residents in the vicinity of those smoke compartments.	
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of			

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	155789	A. BUILDING 02 B. WING	08/13/2024

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	audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct 3rd shift quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review on 08/13/2024 between 10:30 AM and 1:45 PM with the Director of Plant Operations and Maintenance Support, no documentation for a 3rd shift fire drill for the first quarter of 2024 was available for review. Based on interview at the time of record review, the Director of Plant Operations stated he got confused regarding the time third shift started at this facility. This finding was reviewed with the Director of Plant Operations, Maintenance Support, Executive Director, and Director of Health Services at the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	Immediate Intervention The Director of Plant Operations conducted a 3rd shift fire drill. (See Exhibits C,D,E,F) The Director of Plant Operations was educated by the Executive Director on K712- Fire Drills. (See Exhibit A) Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. The Director of Plant Operation will inspect for Fire Drill compliance 1 x week for 1 month and 1 x a month for 3 months. (See Exhibit B) Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice affects all staff, residents and visitors	08/15/2024