STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155791	A. BUILDING -- B. WING	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BLAIR RIDGE HEALTH CAMPUS	269 MEADOWVIEW DR PERU, IN 46970

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/12/24 Facility Number: 012565 Provider Number: 155791 AIM Number: 201021970 At this Emergency Preparedness survey, Blair Ridge 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 a capacity of 55 and had a census of 50 at the time of this survey. Quality Review completed on 08/16/24	E 0000	**K0000** /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /b> /b> /b> /b>	
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: 08/12/24 Facility Number: 012565 Provider Number: 155791 AIM Number: 201021970 At this Life Safety Code survey, Blair Ridge	K 0000	**K0000** /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p> /p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Tinsley	Executive Director	08/30/2024

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.

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	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. This one-story facility was determined to be of Type V111 construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 55 and had a census of 50 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/16/24		/p> /p> /p> /p> /p> /b> /b> /b> /b>	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of			

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	hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 housekeeping door, a hazardous areas greater than 50 square feet in size was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect as many as 10 staff in the vicinity of or working in the service hall. Findings include: Based on observation with the Director of Plant Operations (DPO) during a tour of the facility 08/12/24 at 1:37 p.m., the corridor door to the housekeeping office located in the service hall was propped open with a small box. This office was approximately 400 square feet in size and contained numerous cleaning chemicals, cardboard boxes of miscellaneous supplies, cloth cleaning items, and other combustible items creating a hazardous environment. Based on interview at the time of observation, the DPO	K 0321	=”” span=””> =”” span=””> =”” span=””> =”” span=””> /p> **K 321 1. The facility will ensure that self-closing or automatic closing doors remain free of items impeding closure.** **2. The deficient practice could affect as many as ten staff members near or working in the service hall. All staff were educated on self-closing or automatic closing doors and on remaining free of items impeding closure.** **3. To measure ongoing compliance, the DPO or the Designee will audit all self-closing or automatic closing doors weekly for one**	08/30/2024

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	acknowledged the room was greater than 50 square feet in size, was a hazardous room, and the door to the corridor was propped open. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		**month to ensure they are closed, then every other week for two months, and finally monthly for three months.** **4. As a quality measure, the DPO or the Designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves a hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.** **5. This plan of correction constitutes our credible allegation of compliance with all** regulatory requirements. Our date of compliance is August 30th, 2024	
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 Based on record review and interview, the facility	K 0712	K 712	08/30/2024

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	failed to conduct 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 of the "Fire Drill Report" documentation with the Director of Plant Operations (DPO) on 08/12/24 at 10:34 a.m., there was no documentation for a fire drill being conducted in the first quarter (January, February, and March) of 2024. Based on interview at the time of record review, the DPO acknowledged the aforementioned missing fire drill. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b) 3.1-51(c)		1. The facility will ensure that fire drills are completed quarterly. 2. The deficient practice could affect all staff and residents. The Senior DPO and DPO were educated on deficient practice. 3. To measure ongoing compliance, the ED or the Designee will audit fire drills for one month to ensure completion, then every other week for two months, then monthly for three months. 4. As a quality measure, the ED or the	

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			Designee will review any findings and will review any findings and corrective action at least quarterly and ongoing until the campus achieves a hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 30th, 2024	

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