STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00411140. This visit included a State Residential Licensure Survey. Complaint IN00411140 - No deficiencies related to the allegations are cited. Survey dates: June 15, 16, 19, 20, and 21, 2023 Facility number: 012523 Provider number: 155789 AIM number: 201027870 Census Bed Type: SNF/NF: 33 SNF: 31 Residential: 54 Total: 118 Census Payor Type: Medicare: 13 Medicaid: 29 Other: 22 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 23, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by Ridgewood Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Ridgewood Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Ernest	DHS	07/09/2023

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 00 B. WING	06/21/2023

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
	Based on interview and record review, the facility failed to accurately complete comprehensive MDS (Minimum Data Set) assessments for 3 of 18 resident records reviewed for accuracy of assessments. (Residents 70, 37, and 31) Findings include: 1. The clinical record for Resident 70 was reviewed on 06/16/23 at 1:43 P.M. An Admission MDS assessment, dated 03/21/23, indicated the resident was admitted to the facility from an acute hospital. The diagnoses included, but were not limited to, stroke, coronary artery disease, and diabetes. A Discharge MDS assessment, dated 05/03/23, indicated the resident discharged from the facility and returned to an acute hospital. A Progress Note, dated 05/03/2023 at 10:09 A.M., indicated the resident discharged from the facility and was moving to the Assisted Living facility. The family helped move the resident's belongings, and the facility nurse gave report and resident paperwork to the Assisted Living nurse. During an interview on 06/21/23 at 11:21 A.M., the MDS Coordinator indicated the resident did not discharge to a hospital from the facility on 05/03/23. The resident discharged from the facility and went to the Assisted Living facility. The MDS assessment was incorrect. 2. During an interview on 06/21/23 at 9:37 A.M., while reviewing the psychotropic medications for Resident 37 with the SSD (Social Services Director), it was discovered that the resident was not receiving an antianxiety medication. The clinical record was reviewed on 06/21/23 at 9:20 A.M. A 5-day scheduled MDS assessment,	F 0641	1. Residents 70, 37, and 31 noted to have miscoding on MDS assessments. No residents were affected by this alleged deficiency practice. 2. All resident assessments have the potential to be affected. Residents 70, 37 and 31 MDS assessment have been reviewed and revised for accuracy. (Exhibit A1) All discharged residents in 30 days have been reviewed for accuracy and corrected as warranted. (Exhibit A2) Current in-house residents MDS assessments with antianxiety medications and/or opioid medications have had section N audits to ensure accuracy and modified as warranted. (Exhibit A3) MDSC have been educated on correct coding for discharges and medication classifications per the RAI manual. (Exhibit A4) 3. As a measure of ongoing compliance, the Assessment support nurse or designee will conduct and audit any new resident assessments, sections A2100 to ensure accuracy of proper discharge coding. Audits will be as follows: 3 residents weekly x4 weeks, 3 residents every other week x4 weeks and then 3 residents monthly x4 months. (Exhibit A5) As a measure of ongoing compliance, the Assessment support nurse or designee will conduct and audit any new	07/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	dated 05/30/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, anxiety, and depression. Section "N", medications, indicated the resident had received an antianxiety medication for five of the five days of the review period. During an interview on 06/21/23 at 9:55 A.M., the SSD indicated the resident had not received an antianxiety medication during the review period. The 5-day scheduled MDS assessment, dated 05/30/23, was incorrect. The EMAR (Electronic Medication Administration Record) for May 2023, was provided by the Corporate MDS Support on 06/21/23 at 10:13 A.M. The record lacked a physician's order for an antianxiety medication. During an interview on 06/21/23 at 9:59 A.M., the MDS Coordinator indicated they did not have a policy for completing the MDS assessments, they followed the RAI (Resident Assessment Instrument) manual. 3. During an interview on 06/15/23 at 12:58 P.M., Resident 31 indicated he had pain in both of his arms all the time. The clinical record for Resident 31 was reviewed on 06/21/23 at 11:12 A.M. An Admission MDS assessment, dated 04/28/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, anemia and hypertension. Section "N" lacked documentation that opioids were administered in the seven day look back period. The April 2023 EMAR indicated the resident had received hydrocodone-acetaminophen 5-325 mg		resident assessments, sections N0410B to ensure accuracy of proper antianxiety medication classification coding. Audits will be as follows: 3 residents weekly x4 weeks, 3 residents every other week x4 weeks and then 3 residents monthly x4 months. (Exhibit A6) As a measure of ongoing compliance, the Assessment support nurse or designee will conduct and audit on any new resident assessments, section N410H to ensure accuracy of proper opioid medication classification coding. Audits will be as follows: 3 residents weekly x4 weeks, 3 residents every other week x4 weeks and then 3 residents monthly x4 months. (Exhibit A7) 4. How the corrective action will be monitored to ensure the deficient practice will not reoccur ie. what quality assurance program will be put into place? For quality assurance, the ED and/or designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increase concerns are noted and decrease the frequency of audits if no	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	from 04/24/23 through 04/28/23. During an interview on 06/21/23 at 11:41 A.M., the MDS Coordinator indicated she would obtain resident information for medications usage from the EMAR. The medication usage was a seven day look back and the resident had received the opioid and the MDS should have reflected it. 3.1-31(c)(13) 3.1-31(d)		concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview, observation, and record review, the facility failed to prevent the development of an unstageable (obscured full-thickness skin and tissue loss, full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough, moist dead tissue, or eschar, dry dead tissue) pressure ulcer (Resident 57), and failed to implement Care Plan interventions to prevent the	F 0686	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Resident 57 and resident 2 were affected by the alleged deficient practice. Both residents were assessed by a licensed nurse and found no adverse effects of alleged	07/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	development of pressure ulcers (Resident 2) for 2 of 3 residents reviewed for pressure ulcers. Findings include: 1. During an interview on 06/15/23 at 1:09 P.M., Resident 57 indicated she had skin conditions the facility was treating. They put ointment on her bottom. There was just one tiny place on her bottom now. They put a little patch on it just as a precaution. The resident's sacral/coccyx area was observed with RN 14 on 06/20/23 at 1:57 P.M. There was a pencil eraser sized, light cream-colored scab at the top of the gluteal cleft, and a dime-sized red area on the right buttock. The clinical record was reviewed on 06/21/23 02:13 PM. A Scheduled 5-day MDS (Minimum Data Set) assessment, dated 05/29/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Enterocolitis due to Clostridium difficile (C-diff, a bacterium that causes an infection of the large intestine, colon), heart failure, and malnutrition. The resident was at risk for pressure ulcers and had three stage three pressure ulcers (full-thickness skin loss in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole [rolled wound edges] are often present. Slough and/or eschar, may be visible but does not obscure the depth of tissue loss), that were present on admission, and three unstageable pressure ulcers that were present on admission. A Discharge MDS assessment, dated 04/18/23, indicated the resident had no unhealed pressure ulcers.		deficiency. Resident 57's wound had healed before the survey and has been discharged. Resident 2 has no wounds. Resident 2 has had no adverse effects of the said deficient practice (Exhibit B1) **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** · All residents have the potential to be affected by the alleged deficient practice. · Clinical Staff were reeducated on the wound management program including but not limited to wound treatments and pressure prevention modalities (Exhibit B2) · All like residents with a Braden score of 14 or lower were assessed for skin impairment and placement of preventative interventions. (Exhibit B3) · All like residents with a Braden score of 14 or lower were audited for any deficient practice within the wound management guidelines. (Exhibit B4) **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** As a measure of ongoing compliance, DHS or designee will monitor for the presence of treatment and prevention	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	The resident returned on 04/20/23 from an acute hospital stay. A Discharge MDS assessment, dated 5/20/23, indicated the resident had one stage 3 pressure ulcer that was present on readmission/reentry, and two unstageable pressure ulcers, one of which was present on admission/reentry. A Wound Event Report, dated 05/06/23, was provided by the ADON (Assistant Director of Nursing)/Wound Nurse on 06/20/23 at 4:01 P.M. The report indicated the resident had acquired an open area on her coccyx that measured 0.75 cm (centimeters) x (by) 0.75 cm, that was not present on admission. The treatment was to apply wound gel to the open area and cover with a foam wound dressing, daily, until healed. The Wound Management Detail Report record was provided by the ADON/Wound Nurse on 06/20/23 at 4:01 P.M., and contained the following observations: - 05/09/23, the wound measured 1 cm x 0.5 cm x 0.1 cm deep, had a light amount of serous (clear, amber, thin and watery) drainage, was unstageable, and the wound bed was 25% covered with granulation (new) tissue, and 75% covered in slough. The record indicated the wound healed on 05/22/23. The Treatments Administration History record was provided by the ADON/Wound Nurse on 06/20/23 at 4:01 P.M. Prior to the development of the pressure ulcer on the resident's coccyx, the following treatment order, with a start date of 04/27/23 and a discontinued date of 05/07/23, was		modalities; 5 residents weekly x4 weeks, 5 residents every other week x2 months and 5 residents monthly x3 months and monitored monthly in QAPI for 6 months. (Exhibit B5) 4. How the corrective action will be monitored to ensure the deficient practice will not reoccur ie. what quality assurance program will be put into place? For quality assurance, the ED and/or designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increase concerns are noted and decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	in place for a wound on the resident's sacrum that had been present on readmission: - Sacrum: cleanse wound with wound cleanser or normal saline, apply skin prep (a toughening agent) to peri-wound intact skin, apply Adaptic (a non-adherent dressing) to wound bed and cover with foam dressing, change once a day every five days. - Sacrum: cleanse wound with wound cleanser or normal saline, apply skin prep to peri-wound intact skin, apply Adaptic to wound bed and cover with foam dressing, change once a day every five days PRN (as needed). The record indicated the resident's dressing was applied on 05/02/23, and was discontinued on 05/07/23, after the development of the unstageable pressure ulcer to the resident's coccyx. No treatments were documented from 05/02/23 to 05/06/23, the day the wound was first observed. The Vitals Report record was provided by Corporate MDS Support on 06/21/23 at 11:40 A.M. The record indicated the resident had been incontinent of bowel with a large loose stool on 05/03/23 at 5:53 A.M., had a large liquid bowel movement with a foul odor on 05/04/23 at 10:21 A.M., and had been incontinent of bowel with a large loose stool on 05/06/23 at 2:08 P.M. During an interview on 06/20/23 at 2:38 P.M., the ADON/Wound Nurse indicated the coccyx wound was at the top of the gluteal cleft and that was the new wound identified on 05/06/23. The sacral wound was identified on 04/20/23. The sacral wound was above the coccyx wound. The coccyx wound was closed at this time. Prior to having the unstageable wound on her coccyx, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	resident was getting skin prep applied to the area, along with a sacral dressing treatment order that was changed, starting on 04/27/23. She had a dressing on her sacrum. The sacral dressing covered the sacrum and the coccyx. She had a foam dressing in place as a preventative on 04/07/23. Preventative dressings were usually changed every five days but could stay on for seven days. On 04/27/23, the treatment was changed to adding Adaptic to add moisture to the area and to prevent the other dressing from sticking. The foam dressing was continued as well. The current "Guidelines for Weekly Measurements" policy, with a reviewed date of 12/31/22, was provided by Corporate Clinical Support on 06/21/23 at 2:24 P.M. The policy indicated, "...PURPOSE...To monitor the effectiveness of interventions for pressure reduction, identify areas of skin impairment in the early development stage and implement other preventative and/or treatment measures..." 2. During an observation on 06/15/23 at 1:01 P.M., Resident 2 was lying in bed. Her eyes were closed. A pressure relieving boot was lying in the wheelchair and another one was lying in the recliner. The resident's enteral nutrition supplment (a form of nutrition delivered into the digestive system) was connected to a pump and running through tubing connected to their g-tube (gastrostomy tube) site. During an observation on 06/16/23 at 11:29 A.M., Resident 2 was lying in bed. Her heels were resting on the bed with a pillow under her calves. The pillow appeared flat. A pressure relieving boot was lying in the wheelchair and another one was lying in the recliner. The resident's supplemental nutrition was connected and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	running. The clinical record for Resident 2 was reviewed on 06/19/23 at 10:50 A.M. A Quarterly MDS assessment, dated 05/09/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, anemia, heart failure, hypertension, seizure disorder, anxiety, depression, and bipolar disorder. The resident was at risk for pressure ulcers. The Complete Care Plan was provided by the Cooperate Nurse on 06/20/23 at 3:47 P.M. A Care Plan titled, "Skin Integrity" was developed on 06/01/21, included an intervention to wear offloading boots to the bilateral feet at all times with a start date of 06/01/23. An open-ended physician's order, with a start date of 05/30/23, the staff were to apply offloading boots to the resident's bilateral feet at all times. The staff were to check the placement every shift. During an interview on 06/20/23 at 12:59 P.M., CNA 15 indicated the resident required total assistance of two staff with care. She was comatose and started on hospice the past weekend. She had been sent out to the hospital when she was unresponsive in the facility. During an interview on 06/20/23 at 1:12 P.M., LPN 12 indicated the resident was to wear offloading boots at all times, but she would kick them off. The staff would have to go back in and reapply them. During an interview on 06/20/23 at 3:01 P.M., the ADON indicated the resident was to have the boots on at all times but she would kick them off.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	If the resident wasn't wearing the boots it should be documented. 3.1-40(a)(1) 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure care planned interventions were in place for 1 of 3 residents reviewed for accident hazards. (Resident 3) Findings include: Resident 3's bathroom was observed on 06/16/23 at 11:23 A.M. The resident's call light had several pieces of bright pink colored tap on the pull string. Toilet safety rails were observed in place on each side of the toilet. The rails were gray in color. The resident's clinical record was reviewed on 06/20/23 at 1:55 P.M., A Quarterly MDS (Minimum Data Set) assessment, dated 02/24/23, indicated the resident was severely cognitively impaired. The resident required the extensive assistance of two staff members for transferring, toileting, and personal hygiene. The diagnoses included, but were not limited to, stroke, hemiplegia and	F 0689	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Resident 3 was affected by the alleged deficient practice. Resident had no adverse effects related to the said deficient practice. The brightly colored tape was immediately placed on the safety rails of the toilet seat. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** · All residents have the potential to be affected by the alleged deficient practice. · Clinical Staff were educated on the fall intervention program	07/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	hemiparesis, and diabetes. The resident's vision was severely impaired. The resident's upper and lower extremities were impaired on one side. The resident experienced two or more falls without injury since the last assessment. A progress note, dated 04/10/2023 at 9:39 P.M., indicated the resident was found on the floor in her bathroom. The resident stated she was attempting to transfer herself onto the toilet and missed, landing on her buttock. The resident complained of low back pain but was assessed and found to be without injury. A progress note, dated 04/11/2023 at 9:28 A.M., indicated an interdisciplinary team review determined the root cause of the fall was that the resident missed the toilet when she sat down, likely due to her visual impairment. An intervention to place handles on the toilet and mark them with bright colored tape to improve visibility was implemented. The resident's "Category: Falls" care plan was provided by Corporate Clinical Support on 06/20/23 at 1:48 P.M. Interventions included, but were not limited to, a current intervention, with a start date of 04/11/23, for handles on the toilet marked with bright colored tape to improve visibility. The resident's bathroom was observed with RN 13 on 06/20/23 at 11:33 A.M. There was no brightly colored tape on the safety rails on either side of the resident's toilet. RN 13 indicated she reviewed the resident's care plan, and it did indicate that there should be bright colored tape on the safety rails. The resident's vision was significantly impaired, and she liked the bright pink tape they used.		policy and procedure with concentration on, but not limited to, monitoring that fall interventions are in place, also concentrating on visual cues. (Exhibit B2) - All like residents' care plan interventions were reviewed by the DHS/ADHS/Designee to assure care plan interventions are in place as appropriate. (Exhibit C1) **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** As a measure of ongoing compliance, DHS, or designee with monitor for the presence of appropriate fall interventions in place as per care plan; 5 residents weekly x4 weeks, 5 residents every other week x2 months and 5 residents monthly x3 months and monitored monthly in QAPI for 6 months. (Exhibit C2) 4. How the corrective action will be monitored to ensure the deficient practice will not reoccur ie. what quality assurance program will be put into place? For quality assurance, the ED and/or designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	The current facility policy, titled "Falls Management Program Guidelines", with a review date of 03/16/22, was provided by the Corporate MDS Coordinator on 06/20/23 at 2:43 P.M. The policy indicated, "...strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures..." 3.1-45(a)(2)		quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increase concerns are noted and decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met.	
F 0732 SS=D Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to post nurse staffing daily for 2 of 7 days during the survey period. Findings include: During an observation on 06/15/23 at 10:10 A.M., the nurse staffing was posted by the main entrance and dated for 06/09/23. During an observation on 06/15/23 at 2:48 P.M., the nurse staffing was posted by the main entrance and dated for 06/09/23. During an observation on 06/16/23 at 8:55 A.M., the nurse staffing was posted by the main entrance and dated for 06/09/23. During an interview on 06/21/23 at 1:15 P.M., the Scheduling Coordinator indicated she was responsible for ensuring staffing information was posted each day. She had been on vacation since 06/12/23 and today was her first day back at the facility. Staffing should be posted everyday. During an interview on 06/21/23 at 1:22 P.M., the Administrator indicated the Scheduling Coordinator handled staff posting. When she was	F 0732	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - No residents were adversely affected by the said deficient practice. The daily staffing data was immediately posted. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - -NO residents have the potential to be affected by the said deficient practice. The scheduling coordinator and IDT (interdisciplinary team) were educated on posting the daily staffing sheet daily. (Exhibit D1) **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	07/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	on vacation, several staff members stepped in to update staff posting. The current facility policy, titled "Guidelines for Staff Posting", with a review date on 12/31/22, was provided by Corporate Clinical Support on 06/21/23 at 2:05 P.M. The policy indicated, "...At the beginning of each day the number and amount of hours of licensed nurses...and the number and hours of unlicensed nursing personnel, per shift, who provide direct care to residents will be posted..."		- As a measure of ongoing compliance, DHS or designee with monitor for the presence of daily staffing data sheets posted per policy; 5xs weekly x4 weeks, 5xs every other week x2 months and 5xs monthly x3 months and monitored monthly in QAPI for 6 months. (Exhibit D2) 4. How the corrective action will be monitored to ensure the deficient practice will not reoccur ie. what quality assurance program will be put into place? For quality assurance, the ED and/or designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increase concerns are noted and decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on record review and interview, that facility failed to provide medications for 1 of 18 residents reviewed for pharmacy services. (Resident 46) Findings include: 1a. The clinical record for Resident 46 was reviewed on 06/16/23 at 2:21 P.M. Am Admission MDS (Minimum Data Set) assessment, dated	F 0755	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - An assessment by a licensed nurse revealed that	07/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	05/05/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, malnutrition, and depression. A Progress Note, dated 06/08/23 at 4:24 P.M., indicated the resident's doxepin (an antidepressant medication) was reduced to 5 mg (milligrams) daily for seven days and then discontinue. A Progress Note, dated 06/13/23 at 1:40 P.M., indicated the pharmacy called and they were unable to split the doxepin capsule. The medication only came in 3 mg and 6 mg forms. The NP (Nurse Practitioner) was notified and a new order was obtained to start doxepin 3 mg everyday and continue with the original discontinue date. A physician's order, dated 05/02/23 through 06/08/23, indicated the resident was to receive doxepin 10 mg, once a day. A physician's order, dated 06/08/23 through 06/13/23, indicated the resident was to receive doxepin 5 mg, once a day. A physician's order, dated 06/13/23 through 06/14/23, indicated the resident was to receive doxepin 3 mg, once a day. The June 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident received the following doxepin medications: - On 06/08/23, 06/11/23, 06/12/23, the resident was administered 5 mg, and		Resident 46 had no adverse effects due to alleged deficient practice. (Exhibit E1) **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents have the potential to be affected. All new orders were reviewed to ensure medications were available and given per MD order. (Exhibit E2) ——— Licensed staff were educated on pharmacy manual procedures for medication administration. (Exhibit B2) **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - As a measure of ongoing compliance, DHS or designee will monitor for medication administration compliance during morning clinical care meeting; 5 residents weekly x4 weeks, 5 residents every other week x2 months and 5 residents monthly x3 months and monitored monthly in QAPI for 6 months. (Exhibit E3)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	- On 06/14/23, the resident was administered 3 mg. The resident was not administered medications on 06/09/23, 06/10/23, and 06/13/23 due to the medication being unavailable. A "New Prescription Summary", indicated the medication was a capsule and couldn't be split. The medication was only available in 6 mg and 3 mg. The facility was notified the following dates and times: - On 06/09/23 at 9:15 A.M., a staff member indicated she would clarify the medication with the NP next week, - On 06/10/23 at 3:03 P.M., the facility was faxed, - On 06/12/23 at 5:07 P.M., a staff member indicated she would clarify with the MD, and - On 06/13/23 at 12:55 P.M., a staff member indicated they were still working on clarification. During an interview on 06/21/23 at 10:28 A.M., the pharmacist indicated the doxepin medication was only available in 3 mg and 6 mg. The 10 mg medication was a capsule so the facility would not have been able to cut the previous medication in half. The pharmacy would have alerted the facility the same day the order was inputted that the medication was unavailable in the 5 mg form. The facility had been contacted on the 06/08/23 and 06/09/23. The medication was filled on 06/13/23 as a 3 mg tab. During an interview on 06/21/23 at 1:28 P.M., the Infection Preventionist indicated when a resident had a new medication order it would be transcribed into the computer and the pharmacy would get the medication order. The facility staff would call to make sure they got the order. The resident medications would be delivered the same		4. How the corrective action will be monitored to ensure the deficient practice will not reoccur ie. what quality assurance program will be put into place? For quality assurance, the ED and/or designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increase concerns are noted and decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	day or the next day. If the medication was not available from the pharmacy the staff should call the physician and document in the progress note. The NP should have been notified sooner that the doxepin medication was unavailable in the 5 mg form. 1b. An open-ended physician's order with a start date of 05/01/23, indicated the resident was to be administered alendronate 70 mg, once a day on Monday, for bone health. The June 2023 EMAR/ETAR indicated the resident had not received the medication on 06/05/23 and 06/19/23 due to the medication being unavailable. During an interview on 06/20/23 at 1:07 P.M., LPN 15 indicated when a resident had a new medication order she would see if it was available in their medication bank and if not the she would call the pharmacy to see if she could get it from a back-up pharmacy (local pharmacy). If it came from the back-up it would get to the facility within one hour and a half and two hours. If the medication came from their pharmacy it would take them about four hours. The pharmacy delivered medications every night. The cutoff time to order medications and get them the same night was 12:00 P.M. If the medication was not available the pharmacy would notify the nurse with recommendations and she would call the NP. The NP should be notified the same day or within 24 hours of a medication not being available. During an interview on 06/21/23 at 10:28 A.M., the pharmacist indicated the alendronate was ordered from the pharmacy on 05/01/23 and 06/05/23. The medication was sent as a monthly supply with four tablets.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	During an interview on 06/21/23 at 1:28 P.M., the Infection Preventionist indicated the alendronate medication should have been reordered when the lat dose was given in May. The current facility policy titled, "Unavailable Medications" with a revised date of 11/2018, was provided by the Infection Preventionist on 06/21/23 at 2:38 P.M. The policy indicated, '...The facility must make every effort to ensure that medications are available to meet the needs of each resident..." 3.1-25(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to follow the physician's orders related to hold parameters for hypertension medications for 2 of 7 residents reviewed for unnecessary medications. (Residents 36 and 49) Findings include: 1. The clinical record for Resident 36 was reviewed on 06/20/23 at 3:27 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 04/12/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, chronic obstructive pulmonary disease, and stroke. The current Care Plan for Cardiovascular distress related to the diagnoses of hypertension and hyperlipidemia, with a reviewed date of 04/26/23, was provided by Corporate MDS Support on 06/20/23 at 4:08 P.M. Interventions included, but were not limited to, Medications as ordered, and obtain vital signs as ordered and needed. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for February 2023 was provided by Corporate MDS Support on 06/20/23 at 4:08 P.M. The record included, but was not limited to, the following physician's order: - An open-ended order for metoprolol succinate tablet extended release (a blood pressure medication), 50 mg, once a day, for hypertension. Special Instructions: Hold for Pulse < (less than) 60 or SBP (Systolic Blood Pressure), the top number, < 110, with a start date of 01/19/23, and a discontinued date of 03/17/23.	F 0757	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - An assessment was done for both residents by a licensed nurse revealing that Residents 36 and 49 had no adverse effects from the alleged deficient practice. (Exhibit F1) **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All like residents have the potential to be affected. All residents with physicians 'orders with hold parameters were audited and corrected as warranted with collaboration with medical provider. (Exhibit F2) - Licensed staff were educated on following physicians orders and noting hold parameters. (Exhibit B2) **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - As a measure of ongoing compliance, DHS or designee will monitor for new medication hold orders during morning clinical care meeting; 5 residents weekly x4	07/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	The record indicated the medication had been administered outside of the ordered parameters, when the resident's pulse was less than 60 beats per minute, on the following dates: - On 02/02/23, the pulse was 52, - On 02/03/23, the pulse was 53, - On 02/09/23, the pulse was 56, - On 02/17/23, the pulse was 56, - On 02/19/23, the pulse was 53, - On 02/21/23, the pulse was 53, and - On 02/24/23, the pulse was 53. During an interview on 06/20/23 at 1:47 P.M., RN 14 indicated when a resident had hold parameters on a medication, for like a blood pressure medication, it was usually in the EMAR/ETAR. Staff could see it in the order. Staff should document the required values and notify the NP (Nurse Practitioner) that they were holding the medications. If there were no hold parameters, she would clarify the order with the NP and add parameters if needed. Staff should follow the physician's orders. She had not been inserviced on hold parameters recently. It was a nursing measure. The current Comprehensive Care Plan Guideline policy, with a revised date of 05/22/18, was provided by Corporate MDS Support on 06/20/23 at 2:43 P.M. The policy indicated, "...PURPOSE...To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions..." The current "ADMINISTRATION PROCEDURES FOR ALL MEDICATIONS" policy, with a revised date of "11/18", was provided by Corporate		weeks, 5 residents every other week x2 months and 5 residents monthly x3 months and monitored monthly in QAPI for 6 months. (Exhibit F3) 4. How the corrective action will be monitored to ensure the deficient practice will not reoccur ie. what quality assurance program will be put into place? For quality assurance, the ED and/or designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increase concerns are noted and decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	Clinical Support on 06/21/23 at 9:05 A.M. The policy indicated, "...To administer medications in a safe and effective manner...Check for vital signs, other tests to be done during/prior to medication administration..." 2. The clinical record for Resident 49 was reviewed on 06/19/23 at 10:30 A.M. A Quarterly MDS assessment, dated 05/30/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia, anemia, hypertension, and renal insufficiency. An open-ended physician's order, with a start date of 05/10/23, indicated the staff were to administer metoprolol succinate, 25 mg once a day. The staff were to hold the medication if the resident's systolic blood pressure was less than 120 or the heart rate was less than 60. The May 2023 EMAR indicated the resident had received the medication when the systolic blood pressure was less than 120 on the following date and times: - On 05/10/23, the blood pressure was 106/68, - On 05/12/23, the blood pressure was 112/71, - On 05/19/23, the blood pressure was 111/76, - On 05/20/23, the blood pressure was 114/68, and - On 05/29/23, the blood pressure was 94/61. During an interview on 06/20/23 at 1:07 P.M., LPN 12 indicated if a resident's blood pressure medication had hold parameters, she would check the blood pressure and heart rate prior to giving the medication. She would not administer the medication if it was outside the parameters. The current "ADMINISTRATION PROCEDURES FOR ALL MEDICATIONS" policy, with a revised date of "11/18", was provided by Corporate			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	Clinical Support on 06/21/23 at 9:05 A.M. The policy indicated, "...To administer medications in a safe and effective manner...Check for vital signs, other tests to be done during/prior to medication administration..." 3.1-48(a)(3)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to store medications appropriately for 2 of 3 medication carts reviewed. (200 Hall front	F 0761	**1: What corrective action(s) will be accomplished for those residents found to have**	07/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	medication cart and 200 Hall back medication cart) Findings include: 1. The 200 Hall front medication cart was observed on 06/15/23 at 10:25 AM., with QMA (Qualified Medication Aide) 2. The top drawer contained two nested pill cups that were not labeled with a resident's name or room number. The bottom cup had a large round flat tablet that the QMA identified as a Tums. The top cup contained eight pills. The QMA indicated there were no narcotics in the cup and the resident was taking a nap. The QMA indicated the pills were for Resident 13. The current physician's orders for Resident 13 were provided by the DON (Director of Nursing) on 06/21/23 at 2:47 P.M. The record indicated the resident was to receive the following medications between 6:00 A.M., and 10:00 A.M.: - Amlodipine, - Tums, - Aspirin, - Vitamin D3, - Colace, - Lasix, - Lexapro (an antidepressant), - Tylenol Arthritis, and - Wellbutrin (an antidepressant). 2. The 200 Hall back medication cart was observed on 06/15/23 at 10:40 A.M., with LPN (Licensed Practical Nurse) 3. The drawers of the cart contained the following loose pills: - 5 1/2 small while oval pills, - 2 small yellow oval pills, - 1 medium red round pill, - 1 medium white round pill,		**affected by the deficient practice?** No residents were affected by the deficient practice. LPN #3 and QMA #2 were immediately educated on proper Medication storage. (Exhibit G1) **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents have the potential to be affected. All medication carts were audited for loose pills or medications contained in a cup with no additional findings. (Exhibit G2) - Licensed staff were educated on cart cleanliness/loose pills/pills in a cup in the cart. (Exhibit B2) **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** As a measure of ongoing compliance, DHS or designee will complete random medication cart audits during rounds to ensure loose pills and prefilled medication cups are absent from the cart; audit will be completed 3xs weekly x4 weeks, 3xs every other week x2 months and then monthly x3 months. (Exhibit G3) 4. How the corrective action will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	- 1 large white round pill, - 2 small red/orange teardrop shaped pills, - 1 medium green round pill, - 1/2 of a small green oval pill, and - 1 large dark blue capsule. During an observation and interview, on 06/15/23 at 10:40 A.M., after the loose medications were collected from the bottom of the medication cart draws, the LPN indicated the facility had a pill destroyer bottle they used to destroy medications. Medication cart were suppose to be audited regularly. During an interview on 06/21/23 at 2:47 P.M., the DON indicated she did not have a policy related to presetting medications. It was a standard practice to not preset medications. The current "MEDICATION STORAGE IN THE FACILITY" policy, with a revised date of "11/18", was provided by Corporate Clinical Support on 06/21/23 at 9:05 A.M. The policy indicated, "...Medications and biologicals are stored safely, securely, and properly...Medication storage areas are kept clean..." 3.1-25(b)(1) 3.1-25(o)		monitored to ensure the deficient practice will not reoccur ie. what quality assurance program will be put into place? For quality assurance, the ED and/or designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increase concerns are noted and decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00411140. Complaint IN00411140 - No deficiencies related to	R 0000	The submission of this plan of correction does not indicate an admission by Ridgewood Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	the allegations are cited. Survey dates: June 15, 16, 19, 20, and 21, 2023 Facility number: 012523 Residential Census: 54 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 23, 2023.		living environment provided to the residents of Ridgewood Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to attempt to conduct a fire and disaster drill in conjunction with the local fire department at least every six months. Findings include: During an interview on 06/20/23 at 10:07 A.M., the Director of Plant Operations indicated the local fire department came to the facility once a year for a walk-through inspection, but he had not invited them to participate in any fire drills in the last year. The Fire Drill records, dated July 2022 through June 2023, were provided by the Administrator on 06/20/23 at 10:00 A.M. The records lacked documentation that the local fire department had been contacted to participate in any of the fire drills conducted in the last 12 months. During an interview on 06/21/23 at 1:24 P.M., the Administrator indicated the facility followed the State regulations related to fire drills and didn't have a specific policy.	R 0092	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? No residents were affected by the said deficient practice. Assistant DPO in serviced on invitation of fire department to fire drill every six months. (Exhibit H1) 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected. Fire Chief was contacted for an invitation to a fire and disaster drill with the facility. (Exhibit H2) 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As a measure of ongoing compliance, DPO/ADPO/designee will ensure that the Fire Chief will be invited to our fire and disaster drill every six months. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what	07/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
			quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease frequency of audits if no concerns are noted. ="" span=""> Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. (Exhibit H3) br="">="" span="">="" span="" noted. ongoing="" monitoring="" continue="" past="" 6="" months="" warranted="" until="" 100%="" compliance="" is="" met. ="" (exhibit="" h3)<="" p="">="" span="">="" span="">="" span="">	
R 0247	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
Bldg. 00	(7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, interview, and record review, the facility failed to administer insulin appropriately for 1 of 5 residents reviewed for medication administration. (Resident 304) Findings included: Medication administration was observed on the 500 hall on 06/20/23 at 11:12 A.M., with QMA (Qualified Medication Aide) 10. The QMA entered resident 304's room, tested her blood sugar level, found it to be 184, and returned to the medication cart. The QMA summoned LPN (Licensed Practical Nurse) 11 to administer the resident's insulin. The LPN sorted through the insulin pens in a drawer, removed the resident's Humalog insulin pen, removed the pen cap, applied the needle, held the insulin pen horizontally, turned the dial on the end of the pen to one unit, walked into the resident's room, and administered the insulin. During the observation on 06/20/23 at 11:12 A.M., when LPN 11 prepared the insulin injection for the resident, the LPN did not clean the hub of the insulin pen prior to needle placement. The pen was not held vertically to prime (expel air bubbles that may have accumulated in the pen). The resident's Prescription Order for sliding scale Humalog insulin was provided by Corporate Clinical Support on 06/21/23 at 9:05 A.M. The order indicated for a blood sugar level of 184, the resident was to receive 1 unit of insulin.	R 0247	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident 304 was not affected by the alleged deficient practice. (Exhibit J1) LPN 11 was educated on the proper administration of an insulin pen per manufacture guidelines. (Exhibit J2) 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All like residents have the potential to be affected. All residents taking insulin via a pen were assessed by a nurse for any signs of adverse effects with no findings. (Exhibit J3) All licensed staff were in serviced on insulin pen administration. (Exhibit B2) 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As a measure of ongoing compliance, DHS or designee will monitor insulin pen administration to ensure administration is administered per manufacturers guidelines; audit will be completed 3xs weekly x4 weeks, 3xs every	07/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	06/21/2023

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
	The Humalog insulin package insert was provided by Corporate Clinical Support on 06/21/23 at 9:05 A.M. The instructions for use indicated, "...Pull the pen cap straight off...Wipe the Rubber Seal with an alcohol swab...Push the capped needle straight onto the Pen...Pull off the outer needle shield. Do not throw it away...Prime before each injection...Priming your Pen means removing the air from the needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly...If you do not prime before each injection, you may get too much or toll little insulin...turn the dose knob to select 2 units...Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top...Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window...You should see insulin at the tip of the Needle...If you do not see insulin, repeat priming..." The current "ADMINISTRATION PROCEDURES FOR ALL MEDICATIONS" policy, with a revised date of "11/18", was provided by Corporate Clinical Support on 06/21/23 at 9:05 A.M. The policy indicated, "...To administer medications in a safe and effective manner..."		other week x2 months and then monthly x3 months. (Exhibit J4) 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? For quality assurance, the ED and/or designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increase concerns are noted and decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met.	