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	07/27/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/27/23 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 67. Quality Review completed on 07/31/23	E 0000	Submission of this Plan of Correction does not indicate an admission by Stonecroft Health Campus that the findings and allegations contained herein are accurate and tlue representations of the quality of care and services provided to the residents of Ridgewood Health Campus. This facility recognized it's obligation to provide legally and medically necessa1Y 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 comprehensive health care facilities (for Title 18/19 programs). To this end, this 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. We respectfully request paper review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812) 537-5700. Sincerely, Peninah Wood, Executive Director	
K 0000 Bldg. 01				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Peninah Wood	Executive Director	08/11/2023

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.

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	155789	A. BUILDING 01 B. WING	07/27/2023

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	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: 07/27/23 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 67 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 07/31/23	K 0000	Submission of this Plan of Correction does not indicate an admission by Stonecroft Health Campus that the findings and allegations contained herein are accurate and tlue representations of the quality of care and services provided to the residents of Ridgewood Health Campus. This facility recognized it's obligation to provide legally and medically necessa1Y 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 comprehensive health care facilities (for Title 18/19 programs). To this end, this 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. We respectfully request paper review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812) 537-5700. Sincerely, Peninah Wood, Executive Director	

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K 0321 SS=C 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 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 over 10 hazardous areas such as Laundries (larger than 100 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing	K 0321	K 321 — Hazardous Areas - Enclosure Compliance Date- 8/25/23 Immediate intervention The Director of Plant Operations	08/25/2023

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	155789	A. BUILDING 01 B. WING	07/27/2023

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	or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Laundry. Findings include: Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the Main Building from 1:10 p.m. to 2:40 p.m. on 07/27/23, the corridor door to the clean side of the Laundry was equipped with a magnetic hold open device set to release with fire alarm system activation, latching hardware and a self closing device but the door failed to self close and latch into the door frame when tested to close multiple times. The edge of the door one the handle side of the door kept hitting the door frame which prevented the latching mechanism on the door from protruding into the latching plate on the door frame. Based on interview at the time of the observations, the DPO provided a letter from a door replacement contractor stating a replacement laundry room door was on order from the manufacturer with an estimated time of arrival time for the replacement door would be by 07/31/23 with an estimated install date within 48 hours of receipt of the replacement door. These findings were reviewed with the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		has a replacement fire door on order from Fitzpatrick Construction. The DPO reached out to the contractor for an update on delivery. The new date of delivery on the door from the contractor states that door should be delivered on or before August 23, 2023 and will be installed on or before August 25th . The Director of Plant Operations was educated by the Executive Director on K 321 — Hazardous Areas — Enclosure. Hazardous areas such as Laundries (larger than 100 square feet) are separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. The Director of Plant Operations will inspect the deficient door for compliance 1 x week for 1 month and 1 x a month for 3 months. 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 over 10 residents, staff and visitors in the vicinity of the Laundry. Exhibit A— K 321 Hazardous Areas audit Exhibit B — Photos and other	

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			documentation.	
K 0761 SS=E Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads	K 0761	K 761 — Maintenance, Inspection & Testing - Doors Compliance Date- 7/28/23 Immediate intervention The Director of Plant Operations inspected, tested and documented the oxygen room storage room door for compliance and proper operation. The Director of Plant Operations was educated by the Executive Director on K 761 — Maintenance, Inspection & Testing — Doors. NFPA 80, 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AH]. The Director of Plant Operations witl audit for proper inspection and testing of the oxygen room door 1 x week for 1 month and 1 x a month for 3 months. The 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 over 10 residents, staff and visitors in the vicinity of the oxygen	07/28/2023

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	are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the Beauty Salon by Room 301. Findings include: Based on review of "Annual Inspection of Swinging Fire Door Assemblies" documentation dated September 2022 with the Director of Plant Operations (DPO) during record review from 9:50 a.m. to 12:50 p.m. on 07/27/23, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period did not include all fire doors in the facility. The annual inspection documentation dated September 2022 did not include fire door locations		storage and transfilling room by the Beauty Salon. Exhibit A— K 761 Maintenance, Inspection & Testing — Doors Exhibit D — Photos and other documentation.	

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	for oxygen storage and transfilling rooms in the facility. Based on review of facility blueprint documentation for the Main Building, a 1-hour fire resistance rated wall was constructed for an oxygen storage room by the Beauty Salon by Room 301. Based on interview at the time of record review, the DPO stated the facility has one oxygen storage and transfilling room located inside the Main Building and agreed annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period did not include the fire door location for the oxygen storage and transfilling room inside the facility. Based on observations with the DPO and the Facilities Management Support during a tour of the Main Building from 1:10 p.m. to 2:40 p.m. on 07/27/23, a 1-hour fire resistance rating label was affixed to the hinge side of the corridor door to the oxygen storage and transfilling room by the Beauty Salon by Room 301. Four liquid oxygen containers and seventeen 'E' type oxygen cylinders were stored in the room. Based on interview at the time of record review and of the observations, the DPO agreed it could not be ensured all fire door locations in the facility were included in the most recent annual fire door inspection documentation. These findings were reviewed with the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)			
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR	K 0000	Submission of this Plan of Correction does not indicate an admission by Stonecroft Health	

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	483.90(a). Survey Date: 07/27/23 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 71 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 07/31/23		Campus that the findings and allegations contained herein are accurate and tlue representations of the quality of care and services provided to the residents of Ridgewood Health Campus. This facility recognized it's obligation to provide legally and medically necessa1Y 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 comprehensive health care facilities (for Title 18/19 programs). To this end, this 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. We respectfully request paper review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812) 537-5700. Sincerely, Peninah Wood, Executive Director	
K 0345 SS=B	NFPA 101 Fire Alarm System - Testing and			

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Bldg. 02	Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system in the Legacy Building to assure that it had accurate time and date information in accordance with the requirements of NFPA 101- 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all 29 residents, staff and visitors in the Legacy Building. Findings include: Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the Legacy Building from 2:50 p.m. to 3:40 p.m. on 07/27/23, the time of day for the fire alarm control panel which services the Legacy Building was incorrect. The display read the time of day as 2:33 p.m. at 3:03 p.m. Based on interview at the time of the observations, the DPO agreed the main fire alarm control panel for the Legacy Building did not display the correct time of day. These findings were reviewed with the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)	K 0345	K 345 — Fire Alarm System — Testing and Maintenance Compliance Date- 7/28/23 Immediate intervention The Director of Plant Operations worked with his fire alarm contractor to reprogram the display time on the Legacy fire alarm panel to accurately match the time of day. The Director of Plant Operations was educated by the Executive Director on K 345 Fire Alarm System — Testing and Maintenance. The fire alarm system shall have accurate time and date information in accordance with the requirements of NFPA 101 — 2012 edition, Sections 19.3.3 and 9.6 and NFPA 72 — 2010 edition, Sections 14.1, 14.1.1. The Director of Plant Operations will inspect the fire alarm panel for correct time and date 1 x week for 1 month and 1 x a month for 3 months. The results of these inspections	07/28/2023

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			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 29 residents, staff, and visitors in the Legacy Building. Exhibit A— K 345 Fire alarm system audit Exhibit C— Photos and other documentation	