STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING COMPL					
		155789	B. WI	B. WING 07/27/2023			2023
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP COD 181 CAMPUS DR LAWRENCEBURG, IN 47025					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
TAG E 0000 Bldg	An Emergency Preconducted by the Inaccordance with 42 Survey Date: 07/2 Facility Number: 0 Provider Number: AIM Number: 201 At this Emergency Ridgewood Health compliance with E Requirements for Marticipating Provides 13.73. The facility has 71 the survey, the center of the conduction of the survey of the surv	eparedness Survey was Indiana Department of Health in 2 CFR 483.73. 7/23 012523 155789 1027870 Preparedness survey, Campus was found in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR certified beds. At the time of	E 00		Submission of this Plan of Correction does not indicate a admission by Stonecroft Healt Campus that the findings and allegations contained herein a accurate and tlue representati of the quality of care and servi provided to the residents of Ridgewood Health Campus. T facility recognized it's obligation provide legally and medically necessa1Y care and services its residents in an economic a efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation from prehensive health care facilities (for Title 18/19 progration of this end, this plan of correct shall serve as the credible allegation of compliance with a state and federal requirements governing the management of facility. It is thus submitted as matter of statute only. We respectfully request paper revior this plan of correction. If you need any information or paperwork, please do not hes to contact us at (812) 537-570 Sincerely,	n h re ons ices his on to to nd e or ams). Stion all s ithis a iew	DATE
K 0000 Bldg. 01					Peninah Wood, Executive Dire	ector	

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

Peninah Wood

TITLE

Executive Director

(X6) DATE 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

other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: T4SE21 Facility ID: 012523 If continuation sheet Page 1 of 10

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155789		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/27/2023	
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS		181 CA	ADDRESS, CITY, STATE, ZIP COD MPUS DR ENCEBURG, IN 47025		
	SUMMARY: (EACH DEFICIEN REGULATORY OR A Life Safety Code Licensure Survey w Department of Heal 483.90(a). Survey Date: 07/27. Facility Number: 0 Provider Number: AIM Number: 2010 At this Life Safety One Health Campus was Requirements for Pomedicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (I. Health Care Occupated Ridgewood Health Separate buildings. 01, is a one story but be of Type V (111) sprinklered. The Lot located to the south building was deterning the safety of the south building was deterning to the safety of the south building was deterning to the safety of the south building was deterning to the safety of the south building was deterning to the safety of the safety of the south building was deterning to the safety of the	MPUS STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Recertification and State as conducted by the Indiana th in accordance with 42 CFR (23 12523 155789 027870 Code survey, Ridgewood found not in compliance with articipation in (42 CFR Subpart 483.90(a), re and the 2012 Edition of the etion Association (NFPA) 101, (SC), Chapter 19, Existing uncies and 410 IAC 16.2. Campus consists of two The Main Campus, Building tilding and was determined to construction and fully tegacy Building, Building 02, east of the Main Campus hined to be of Type V (111)		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY) Submission of this Plan of Correction does not indicate a admission by Stonecroft Heal Campus that the findings and allegations contained herein a accurate and tlue representat of the quality of care and serv provided to the residents of Ridgewood Health Campus. If facility recognized it's obligation provide legally and medically necessa1Y care and services its residents in an economic a efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation of comprehensive health care facilities (for Title 18/19 progration to the composition of compliance with state and federal requirement governing the management of facility. It is thus submitted as matter of statute only. We respectfully request paper revents.	an th are ions ices This on to to and he for ams). ction all s f this a
	have a fire alarm sy the corridors, in all has smoke detectors system in all resider has a capacity of 71 time of this survey. All areas where resi were sprinklered an services were sprint	lly sprinklered. Both buildings stem with smoke detection in areas open to the corridor and shard wired to the fire alarm at sleeping rooms. The facility and had a census of 67 at the dents have customary access d all areas providing facility clered.		for this plan of correction. If you need any information or paperwork, please do not hes to contact us at (812) 537-570 Sincerely, Peninah Wood, Executive Dir	itate 00.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T4SE21

Facility ID: 012523

If continuation sheet

Page 2 of 10

08/14/2023 PRINTED: FORM APPROVED

ENTERS FO	OM	OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155789 NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/27/2023		
		181 C	ADDRESS, CITY, STATE, ZIP COD AMPUS DR ENCEBURG, IN 47025			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
K 0321 SS=C Bldg. 01	NFPA 101 Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-f (with 3/4 hour fire automatic fire ext accordance with approved automa option is used, th from other space partitions and do Doors shall be se automatic-closing nonrated or field- do not exceed 48 the door. Describe the floo hazardous areas REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fue b. Laundries (larg c. Repair, Mainte d. Soiled Linen R gallons) e. Trash Collectio (exceeding 64 ga f. Combustible St (over 50 square f	s - Enclosure s - Enclosure are protected by a fire nour fire resistance rating a rated doors) or an inguishing system in 8.7.1 or 19.3.5.9. When the atic fire extinguishing system a areas shall be separated by smoke resisting are in accordance with 8.4. aff-closing or and permitted to have applied protective plates that a inches from the bottom of and zone locations of that are deficient in Automatic Sprinkler N/A I-Fired Heater Rooms are than 100 square feet) anance, and Paint Shops and Rooms allons) are growns/Spaces are the classified as Severe are stance.				
	Based on observati	ion and interview, the facility of over 10 hazardous areas such	K 0321	K 321 — Hazardous Areas - Enclosure		08/25/2023

as Laundries (larger than 100 square feet) were

separated from other spaces by smoke resistant

partitions and doors. Doors shall be self closing

Compliance Date- 8/25/23

The Director of Plant Operations

Immediate intervention

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155789		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/27/2023		
	NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS		181 CA	ADDRESS, CITY, STATE, ZIP COD AMPUS DR ENCEBURG, IN 47025		
	(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
	TAG	`	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
			g in accordance with 7.2.1.8.		has a replacement fire door o	n
		•	ice could affect over 10 visitors in the vicinity of the		order from Fitzpatrick Construction. The DPO reach	od
		Laundry.	visitors in the vicinity of the		out to the contractor for an up	
		Launary.			on delivery. The new date of	date
		Findings include:			delivery on the door from the	
		C			contractor states that door she	ould
		Based on observation	ons with the Director of Plant		be delivered on or before Aug	ust
		Operations (DPO) a	and the Facilities Management		23, 2023 and will be installed	on or
			ur of the Main Building from		before August 25th .	
			m. on 07/27/23, the corridor		The Director of Plant Operation	•
			de of the Laundry was		was educated by the Executiv	
			gnetic hold open device set to		Director on K 321 — Hazardo	us
		release with fire alarm system activation, latching			Areas — Enclosure.	
			closing device but the door		Hazardous areas such as	
			and latch into the door frame		Laundries (larger than 100 sq	•
			e multiple times. The edge of		feet) are separated from other	ſ
			ndle side of the door kept ne which prevented the		spaces by smoke resistant	noll
			non the door from protruding		partitions and doors. Doors shad be self-closing or automatic	Iall
			ate on the door frame. Based			
			time of the observations, the		closing in accordance with 7.2.1.8.	
			ter from a door replacement		The Director of Plant Operation	ons
			replacement laundry room		will inspect the deficient door	•
		door was on order f	rom the manufacturer with an		compliance 1 x week for 1 mg	
		estimated time of an	rrival time for the replacement		and 1 x a month for 3 months	
		door would be by 0	7/31/23 with an estimated		Results of these inspections v	vill
		install date within 4	8 hours of receipt of the		be presented by Executive	
		replacement door.			Director to the QA committee	
					further recommendations and	
		_	e reviewed with the DPO and		continue until the Quality	
			gement Support during the exit		Assurance Team determines	
		conference.			substantial compliance has be achieved.	een
		3.1-19(b)			The deficient practice could a	ffect
		5.1 17(0)			over 10 residents, staff and vi	
					in the vicinity of the Laundry.	5516
					Exhibit A— K 321 Hazardous	
					Areas audit	
					Exhibit B — Photos and other	
				•	•	•

STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUM		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155789	B. W	B. WING			07/27/2023	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				MPUS DR			
PIDGEW	OOD HEALTH CAN	ADI IS			ENCEBURG, IN 47025			
RIDGEW	OOD HEALTH CAN	WF 03		LAWIN	ENCEBONG, IN 47023			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					documentation.			
K 0761								
SS=E								
Bldg. 01								
		view, observation and	K 0	761	K 761 — Maintenance, Inspec	tion	07/28/2023	
		ty failed to ensure annual			& Testing - Doors			
	_	ng of all fire door assemblies			Compliance Date- 7/28/23			
	•	accordance of LSC 19.1.1.4.1.1.			Immediate intervention			
		enings in dividing fire barriers			The Director of Plant Operatio			
		1.1 shall be permitted only in			inspected, tested and docume			
		be protected by approved			the oxygen room storage roon			
		or assemblies. (See also Section			door for compliance and prope) r		
	· ·	penings required to have a fire			operation.			
		Table 8.3.4.2 shall be			The Director of Plant Operatio			
		red, listed, labeled fire door			was educated by the Executiv			
		window assemblies and their			Director on K 761 — Maintena			
	closing devices, and	ware, including all frames,			Inspection & Testing — Doors			
	_	requirements of NFPA 80,			NFPA 80, 5.2.1 states fire doc			
		oors and Other Opening			assemblies shall be inspected			
		as otherwise specified in this			tested not less than annually, a written record of the inspecti			
	_	.1 states fire door assemblies			· ·	OH		
		nd tested not less than		shall be signed and kept for inspection by the AH].				
	_	ten record of the inspection			The Director of Plant Operatio	ne		
	•	kept for inspection by the			witl audit for proper inspection			
	_	.3.1 states functional testing of			testing of the oxygen room do			
		w assemblies shall be			x week for 1 month and 1 x a	51 1		
		duals with knowledge and			month for 3 months.			
		e operating components of			The results of these inspection	าร		
	_	ng subject to testing. NFPA			will be presented by Executive			
		e door assemblies shall be			Director to the QA committee			
	·	rom both sides to assess the			further recommendations and			
	overall condition of				continue until the Quality			
		-			Assurance Team determines			
	NFPA 80, Section 5	5.2.4.2 states as a minimum, the			substantial compliance has be	en		
	following items sha	ll be verified:			achieved.			
	(1) No open holes o	r breaks exist in surfaces of			The deficient practice could af	fect		
	either the door or fra				over 10 residents, staff and vis			
	(2) Glazing, vision l	light frames, and glazing beads			in the vicinity of the oxygen			

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155789		l í	LDING	01	COMPL 07/27/	ETED
NAME OF	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP COD MPUS DR		
RIDGE\	WOOD HEALTH CAN	MPUS		LAWRE	NCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
140	are intact and secur equipped. (3) The door, frame noncombustible thr and in working orded damage. (4) No parts are mis (5) Door clearances listed in 4.8.4 and 6 (6) The self-closing the active door comfrom the full open p (7) If a coordinator closes before the active door when it is in the self-closing the active door when it is in the self-closing hardward door when it is in the self-closes before the active door when it is in the self-closes befor	ely fastened in place, if so a, hinges, hardware, and eshold are secured, aligned, er with no visible signs of ssing or broken. do not exceed clearances 3.1.7. device is operational; that is, expletely closes when operated bosition. is installed, the inactive leaf tive leaf. are operates and secures the ne closed position. For items that interfere or are not installed on the door or fications to the door assembly ed that void the label. edge seals, where required, are their presence and integrity. ice could affect over 10 visitors in the vicinity of the transfilling room by the			storage and transfilling room be the Beauty Salon. Exhibit A— K 761 Maintenance Inspection & Testing — Doors Exhibit D — Photos and other documentation.	e,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T4SE21

Facility ID: 012523

If continuation sheet Page 6 of 10

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

PRINTED: 08/14/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	COMPLETED 07/27/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 181 CAMPUS DR LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	facility. Based on redocumentation for the resistance rated wall oxygen storage room Room 301. Based of record review, the Doxygen storage and inside the Main Builinspection document in the facility within period did not include the oxygen storage at the facility. Based of and the Facilities M tour of the Main Builinspection document of the Main Builinspection document of the Main Builinspection to the oxygen storage at the facilities of the facilities of the facilities of the facilities of the main Builing of the Main B	and transfilling rooms in the eview of facility blueprint the Main Building, a 1-hour fire I was constructed for an in by the Beauty Salon by on interview at the time of DPO stated the facility has one transfilling room located Iding and agreed annual tation of fire door assemblies in the most recent twelve month de the fire door location for and transfilling room inside on observations with the DPO anagement Support during a silding from 1:10 p.m. to 2:40 1-hour fire resistance rating the hinge side of the corridor storage and transfilling room in by Room 301. Four liquid and seventeen 'E' type oxygen and in the room. Based on the of record review and of the PO agreed it could not be a locations in the facility were at recent annual fire door tation.					
K 0000							
Bldg. 02	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000	Submission of this Plan of Correction does not indicate a admission by Stonecroft Healt			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T4SE21

Facility ID: 012523

If continuation sheet

Page 7 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 07/27/2023 155789 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 181 CAMPUS DR RIDGEWOOD HEALTH CAMPUS LAWRENCEBURG, IN 47025 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 483.90(a). Campus that the findings and allegations contained herein are Survey Date: 07/27/23 accurate and tlue representations of the quality of care and services Facility Number: 012523 provided to the residents of Provider Number: 155789 Ridgewood Health Campus. This AIM Number: 201027870 facility recognized it's obligation to provide legally and medically At this Life Safety Code survey, Ridgewood necessa1Y care and services to Health Campus was found not in compliance with its residents in an economic and Requirements for Participation in efficient manner. The facility Medicare/Medicaid, 42 CFR Subpart 483.90(a), hereby maintains it is in Life Safety from Fire and the 2012 Edition of the substantial compliance with the National Fire Protection Association (NFPA) 101, requirements of participation for Life Safety Code (LSC), Chapter 19, Existing comprehensive health care Health Care Occupancies and 410 IAC 16.2. facilities (for Title 18/19 programs). To this end, this plan of correction Ridgewood Health Campus consists of two shall serve as the credible separate buildings. The Main Campus, Building allegation of compliance with all 01, is a one story building and was determined to state and federal requirements be of Type V (111) construction and fully governing the management of this sprinklered. The Legacy Building, Building 02, facility. It is thus submitted as a located to the southeast of the Main Campus matter of statute only. We building was determined to be of Type V (111) respectfully request paper review construction and fully sprinklered. Both buildings for this plan of correction. have a fire alarm system with smoke detection in If you need any information or the corridors, in all areas open to the corridor and paperwork, please do not hesitate has smoke detectors hard wired to the fire alarm to contact us at (812) 537-5700. system in all resident sleeping rooms. The facility Sincerely, has a capacity of 71 and had a census of 71 at the Peninah Wood, Executive Director 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 0345 NFPA 101 SS=B Fire Alarm System - Testing and

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T4SE21

Facility ID: 012523

If continuation sheet

Page 8 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155789		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY COMPLETED 07/27/2023		
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP COD 181 CAMPUS DR LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
Bldg. 02	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on observation failed to maintain the Legacy Building to time and date information of NF 19.3.4 and 9.6 and N Sections 14.1, 14.1. affect all 29 resident Legacy Building. Findings include: Based on observation Operations (DPO) a Support during a total 2:50 p.m. to 3:40 p. for the fire alarm con Legacy Building was the time of day as 2 interview at the time agreed the main fire Legacy Building did of day. These findings were	m is tested and maintained an approved program erequirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available.	K 0345	K 345 — Fire Alarm System — Testing and Maintenance Compliance Date- 7/28/23 Immediate intervention The Director of Plant Operation worked with his fire alarm contractor to reprogram the display time on the Legacy fire alarm panel to accurately mat the time of day. The Director of Plant Operation was educated by the Executive Director on K 345 Fire Alarm System — Testing and Maintenance. The fire alarm system shall he accurate time and date inform in accordance with the requirements of NFPA 101 — 2012 edition, Sections 19.3.3 9.6 and NFPA 72 — 2010 editions 14.1, 14.1.1. The Director of Plant Operation will inspect the fire alarm panel correct time and date 1 x ween 1 month and 1 x a month for 3 months. The results of these inspection	ensech ensech ensech ansech and etion, ensech for k for	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T4SE21 Facil

Facility ID: 012523

If continuation sheet

Page 9 of 10

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

PRINTED: 08/14/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155789	` ′	JILDING	ONSTRUCTION 02	(X3) DATE COMPL 07/27 /	ETED
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 181 CAMPUS DR LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					will be presented by Executive Director to the QA committee further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved. The deficient practice could af all 29 residents, staff, and visit in the Legacy Building. Exhibit A— K 345 Fire alarm system audit Exhibit C— Photos and other documentation.	for en fect	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: T4SE21 Facility ID: 012523 If continuation sheet Page 10 of 10