STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185145	A. BUILDING _____ B. WING _____	R 03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	INITIAL COMMENTS An off-site desk review was conducted on 03/25/2024. Based on the acceptable Plan of Correction (POC), the deficiencies were deemed to be corrected on 03/21/2024, as alleged.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	185145	A. BUILDING 02 - CEDAR RIDGE HEALTH CAMPUS B. WING _____	R 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
{K 000}	INITIAL COMMENTS Based on the on-site revisit survey conducted on 06/13/2024 and the acceptable Plan of Correction (POC), it was determined the deficiencies were corrected on 04/01/2024, as alleged.	{K 000}		

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	185145	A. BUILDING 02 - CEDAR RIDGE HEALTH CAMPUS B. WING _____	R 06/13/2024

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{K 000}	INITIAL COMMENTS Based on the on-site revisit survey conducted on 06/13/2024 and the acceptable Plan of Correction (POC), it was determined the deficiencies were corrected on 04/12/2024, as alleged.	{K 000}		

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	185145	A. BUILDING _____ B. WING _____	C 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS A Standard Recertification Survey in conjunction with an Abbreviated Survey investigating KY00037107, KY00038310, and KY00039302 was initiated on 02/06/2024 and concluded on 02/09/2024. KY00037107, KY00038310, and KY00039302 had no deficient practice related to the allegations cited. Deficient practice was identified at 42 CFR 483.60 Food and Nutrition Services, with the highest Scope and Severity at an "F" level. Census: 50.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/04/2024

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies, it was determined the facility	F 812	This plan of correction is to serve as Cedar Ridge Health Campus□ credible	3/21/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/04/2024

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	185145	A. BUILDING _____ B. WING _____	02/09/2024

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F 812	Continued From page 1 failed to prepare and store food under sanitary conditions. Observation of the kitchen on 02/06/2024 revealed staff did not perform hand hygiene between glove changing and tasks. Observation of the Skilled nourishment room on 02/07/2024 revealed non-food items stored with food items and undated food items. The findings include: Review of the facility's policy titled "Guideline for Handwashing/Hand Hygiene," dated 12/31/2023, revealed all health care workers shall utilize hand hygiene frequently and appropriately. Per the policy, hand hygiene should be performed after removing gloves, with gloves worn as directed with Standard Precautions; before and after eating; and after toileting. Review of the facility's policy titled, "Food Safety and Handling," dated 06/2016, revealed date marking must be done when food was Time and Temperature Foods (TTF), Ready to Eat (RTE) foods, which was refrigerated and held more than twenty-four (24) hours. Per the policy, the RTE potentially hazardous foods must be marked with the date of preparation and must be consumed or discarded within seven (7) days, including the day of preparation. Review of the facility's policy titled, "Storage Procedures," dated 01/2023, revealed food storage areas were used for food and paper supplies. Per the policy, chemical/poisonous items were not stored in the food storage area. Open packages were labeled, dated, and stored in closed containers. Dry bulk foods were stored in plastic containers with tight covers or bins which were easily sanitized. Stock was dated	F 812	allegation of compliance. Submission of this plan of correction does not constitute an admission by Cedar Ridge or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. Attached you will find our plan of correction for Cedar Ridge Health campus for our annual survey conducted on 02/09/2024. We initiated immediate interventions when concerns were identified on this date and began re-education for staff as well. We respectfully request paper/desk review for this plan of correction. If you need any information or paperwork, please contact me at (859) 234-2702. The Statement of Deficiencies states that it was determined that the facility failed to prepare and store food under sanitary conditions. Observation of the kitchen on 02/06/2024 revealed staff did not perform hand hygiene between glove changing. Observation of the skilled nourishment room on 02/07/2024 revealed non-food items stored with food items and undated food items. Observation of the kitchen on 2/6/2024 revealed multiple food items opened, but not labeled and dated as well as a dented can.	

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F 812	Continued From page 2 and rotated so that the oldest items were used first. Observation on 02/06/2024 at 10:00 AM on the initial tour of the kitchen revealed an ingredient bin with no label or date which contained a white powder looking product. Observation of the walk-in refrigerator revealed five (5) bags, each containing five (5) pounds of shredded cheddar cheese. These cheddar cheese bags were not dated. Also, on the top shelf, there was a small piece of white cheese covered in clear wrap with no label or date. Continued observation of the dry storage area revealed a number 303 (volume approximately two (2) cups and weight approximately fifteen (15) to seventeen (17) ounces) size can of cream of chicken soup, which had a dent the size of the palm of a hand. In addition the following cans were not dated: five (5) number 303 cans of clam juice; three (3) cans of light red kidney beans; one (1) can of sliced peaches; two (2) cans of peach filling; three (3) cans of lemon pudding; one (1) can of applesauce; three (3) cans of hot fudge sauce; two (2) cans of diced tomatoes; nine (9) cans of fancy tomato sauce; three (3) cans of pizza sauce; and two (2) cans of diced tomatoes. Further observation revealed cake mix on a shelf in a clear zip lock bag not sealed and not dated; opened brownies mix and cake mix on a shelf not dated or closed; and an opened bag of long grain rice on a shelf not dated. Observation on 02/06/2024 at 11:50 AM and 11:55 AM revealed Dietary staff changed gloves between tasks, with no hand hygiene/washing between the change. Observation on 02/07/2024 at 10:00 AM of the	F 812	There were no Residents affected, however, all Residents have the potential to be affected, therefore all food items related to the deficient practice were immediately discarded on 2/9/2024 and the pantry and nourishment rooms deep cleaned. All facility staff were re-educated on 02/07/2024 by the Executive Director and Director of Health Services on the Guideline for Handwashing/Hand Hygiene as well as Food Safety and Handling Standards of Practice as it pertains to both the kitchen as well as resident nourishment rooms. 100% of facility employees acknowledged their understanding of the standards of practice. On 2/12/2024 all dining services employees were asked to demonstrate understanding of the Guideline for Handwashing/Hand Hygiene as evidenced by demonstrating proper hand washing and glove changing. 100% of dining services employees were able to demonstrate proper handwashing/hand hygiene and glove changing protocol. In addition, all dining services employees were asked to demonstrate their understanding of the Food Safety and Handling standards of practice as evidenced by labeling and dating all resident food items within the facility. This procedure was checked off by the Director of Food Services on 2/12/2024. 100% of dining services employees were able to	

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F 812	Continued From page 3 Skilled Unit revealed the nourishment room freezer with ice packs in the freezer door. Further observation revealed the refrigerator contained an undated Golden Kens Italian 1.5 ounce packet, in a foam Mr. Snappy Cup. Also, observation revealed one (1) staff member's personal cup with a black lid and one (1) wrapped pumpkin cookie not dated on the nourishment room counter. During interview with Dining Services Assistant #1 on 02/09/2024 at 10:01 AM, she stated, to prevent cross contamination, hand washing was required between changing gloves, after using the bathroom, and when changing tasks. She stated opened foods should be covered and a date label attached to show when the food would expire. She stated if an expiration date was not on the food item it must be thrown out because expired food could make the resident sick because the food could have soured. She stated cans were placed on the rack so that the cans received first would be used first. She explained the method to rotate food was first in/first out (FIFO) or to first use the food item which had been in stock the longest. During interview with Cook #1 on 02/09/2024 at 10:10 AM, she stated washing hands, to prevent cross contamination, was required when entering the kitchen, between changing gloves, when touching anything, and when changing tasks. She stated staff used the "print genie" to label food in the walk-in refrigerator and to rotate food on the shelf. She stated the ingredient bin must be labeled and dated with the food product's information to prevent the wrong food ingredient being used to prepare food. She stated rotating and dating food would prevent food from being	F 812	demonstrate proper use of the date genie labeling system by labeling and dating and properly storing all food items within the kitchen as well as in resident nourishment rooms, when restocking them. The Director of Food Services or the Assistant Director of Food Services, will complete a daily audit starting 02/12/2024 utilizing the Labeling/Dating and Food Storage Audit tool which includes auditing that all food items are being labeled and dated, checking for dented cans and open food items on shelves to ensure the facility is following the Food Safety and Handling standard of practice within the kitchen and resident nourishment rooms daily for 30 days and then weekly for (3) months to verify ongoing compliance. In addition, the Director of Food Services or the Assistant Director of Food Services will complete a daily audit starting 3/12/2024 utilizing the Hand Hygiene and Glove Changing tool monitoring all dining services employees that are currently working in the kitchen for proper hand/hygiene and glove changing protocol daily for 30 days and then weekly for (3) months to verify ongoing compliance. The audit tool will be utilized randomly each day across different dining services employees and working shifts in the kitchen. Any necessary corrective action will be taken immediately during the audits. The Director of Food Services will present both audit findings to the Executive	

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F 812	Continued From page 4 used that might be spoiled. She stated food not dated or labeled was thrown out, and a dented can would be sent back to the food supplier. During interview with the Director of Dining Services on 02/09/2024 at 10:24 AM, she stated she expected staff members to wash hands after every task and/or between changing gloves. She stated her expectation was for staff members to use the "print genie" to produce a date sticker and place it on the food product and rotate cans first in and first out (FIFO) to prevent outdated food product from being used. She stated for food items left opened, a potential was created for cross contamination and bug infestation. During an interview with the Director of Health Services on 02/09/2024 at 1:46 PM, she stated her expectation was for staff to wash hands any time they were soiled or between glove changes. She stated hand hygiene was important to protect the residents from cross contamination. She stated staff must date food when opened and when received into the kitchen. She stated if food was stored with non-food items, the potential existed for physical and chemical cross contamination. During an interview with the Executive Director (ED) on 02/09/2024 at 2:22 PM, she stated her expectations were for Dietary staff to wash hands with soap and water when indicated; to date food and use the First in and First Out (FIFO) method for storage; and to keep food items and non-food items in separate locations and stored safely.	F 812	Director and/or Director of Health Services and Medical Director weekly during the Weekly Medical Director Report, held every Wednesday. The first date of the presentation of audit findings will be 3/20/2024. All audits will further be reviewed and discussed at the Quality Assurance Performance Improvement meetings held monthly. The following staff are the members of Quality Assurance Performance Committee: Executive Director, Director of Health Services, Medical Director or his designee, Infection Control and Prevention Officer, and at least two of members of the facility staff, including by not limited to: Assistant Director of Health Services, MDS Coordinator, Director of Social Services, Therapy Program Director, Medical Records Clerk, Director of Life Enrichment, Director of Plant Operations/Environmental Services, Business Office Manager, Consultant Pharmacist, Director of Dining Services. The date of the first monthly QAPI review of the Labeling/Dating and Food Storage Audit findings was 3/6/2024. The date of the first monthly QAPI review of the Hand Hygiene and Glove Changing audit will be 4/3/2024. Alleged date of compliance for facility: March 21, 2024.	

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	185145	A. BUILDING _____ B. WING _____	02/08/2024

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E 000	Initial Comments 42 CFR 483.73 Type of Structure: One (1) Story (2004, 2016), Type V (111), unprotected combustible construction with seven (7) smoke compartments and a complete automatic dry sprinkler system. An Emergency Preparedness Survey was conducted on 02/08/2024. During this Recertification Survey, Cedar Ridge Health Campus was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.	E 000		

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K 000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 2004, 2016 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: One (1) story (2004,2016) Type V (111), unprotected combustible construction with seven (7) smoke compartments and a complete automatic dry sprinkler system. A Life Safety Code Recertification Survey was conducted, on 02/08/2024, in accordance with 42 Code of Federal Regulations, Part 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, Cedar Ridge Health Campus was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.90 (a) et seq. (Life Safety from Fire).	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 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	K 321		3/5/24

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K 321	Continued From page 1 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) This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide separation of hazardous areas from other areas in the facility in accordance with National Fire Protection Association (NFPA) standards. The deficient practice affected one (1) of seven (7) smoke compartments, staff, and forty (40) residents. The facility had the capacity for fifty three (53) beds with a census of fifty (50) on the day of the survey. The findings include: Observation, during the building inspection tour on 02/08/2024 at 12:25 PM, revealed the work room/copy room adjacent to the Executive Director's office was over fifty (50) square feet	K 321	The submission of this plan of correction does not indicate an admission by Cedar Ridge Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Cedar Ridge 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 all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185145	A. BUILDING 02 - CEDAR RIDGE HEALTH CAMPUS B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 321	Continued From page 2 and used to store combustible materials. The work room/copy room was not equipped with a self-closing or automatic closing door. In an interview on 02/08/2024 at 12:26 PM with the Senior Director of Plant Operations (SDPO), he stated the facility was not aware of the requirement of the self-closing or automatic closing door for this room. The finding was acknowledged by the Executive Director and verified by the SDPO at the exit interview on 02/08/2024. Actual NFPA Standard: NFPA 101, (2012), 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1 19.3.2.1.3 The doors shall be self-closing or automatic closing. 4.6.12 Maintenance, Inspection, and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction.	K 321	K321 ▯ Hazardous Areas ▯ Enclosed Compliance Date 03/05/2024 Immediate Intervention The Director of Plant Operations immediately installed a self-closing device to workroom/copy room door. The Director of Plant Operations was Educated by the Executive Director on NFPA 101, (2012) 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. 19.3.2.1.3 The doors shall be self-closing or automatic closing. The Director of Plant Operations will audit all hazardous areas for self-closing device, operation of the self-closing device and for proper latching into the frame 1 X per week X 8 weeks. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice affected one of seven smoke compartments, staff and forty residents. The facility had the capacity for fifty three beds with a census of fifty on the day of survey.	
K 351 SS=F	Sprinkler System - Installation	K 351		4/1/24

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K 351	Continued From page 3 CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to install a complete automatic sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficient practice affected seven (7) of seven (7) smoke compartments, staff, and all residents. The facility had the capacity for fifty three (53) beds with a census of fifty (50) on the day of the survey. The findings include: 1. Observation, during the building inspection tour on 02/08/2024 at 11:33 AM, revealed the Fire Department Connections for the sprinkler risers	K 351	K351 (1) ▫ Sprinkler System ▫ Installation Compliance date 03/05/2024 Immediate intervention The Director of Plant Operations installed appropriate signage for the Fire Department Connection for the sprinkler risers. The Director of Plant Operations was educated by the Executive Director on NFPA 13R 6.11.3. Each fire department connection shall be designated by a sign. The Director of Plant Operations will	

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K 351	Continued From page 4 were not labeled with appropriate signage. In an interview on 02/08/2024 at 11:34 AM with the Senior Director of Plant Operations (SDPO), he stated that the facility was not aware the Fire Department Connections were not labeled with appropriate signage. 2. Observation, during the building inspection tour on 02/08/2024 at 12:21 PM, revealed one (1) sprinkler missing the escutcheon located in the bathroom of Room 308. In an interview, on 02/08/2024 at 12:22 PM with the SDPO, he stated the facility was not aware the sprinkler was missing the escutcheon. 3. Observation, during the building inspection tour on 02/08/2024 at 2:46 PM, revealed four (4) skylights located above the Dining Room and two (2) skylights located above the Administration Lobby. Each skylight did not have sprinkler protection or plastic covers installed in the skylights. The skylights were each less than thirty-two (32) square feet and less than ten (10) feet apart. In an interview on 02/08/2024 at 2:47 PM with the SDPO, he stated the facility was not aware the skylights needed sprinkler protection or plastic covers. The findings were verified by the SDPO at the time of observation and the Executive Director at the exit conference on 02/08/2024. Actual NFPA Standard: NFPA 101, (2012) 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved,	K 351	visually audit Fire Department Connection for appropriate signage 1 X per week X 8 weeks Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice affected seven of seven smoke compartments, staff, and all residents. The facility had the capacity for fifty-three beds with a census of fifty on the day of the survey. K351 (2) □ Sprinkler System □ Installation Compliance date 03/05/2024 Immediate intervention The Director of Plant Operations as replaced the missing escutcheon located in the bathroom of room 308. The Director of Plant Operations was educated by the Executive Director on NFPA 13 (2010), 6.2.7 Escutcheons and Cover Plates. 6.2.7.1. The Director of Plant Operations will complete single inspection of the facility verifying that all escutcheons for the sprinkler heads are installed. If missing escutcheons have been identified, these locations will have escutcheons installed immediately. This audit will be followed by a semi-annual audit of the facility. The semi □ annual inspection will be uploaded as a task for the facility into the TELS	

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K 351	Continued From page 5 supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7.1 Automatic Sprinklers. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems (2) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (3) NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height 6.11* Fire Department Connection. 6.11.1 At least one fire department connection shall be provided for buildings, accessible by a fire department, that exceed 2000 ft2 (186 m2) or are more than a single story. 6.11.2 Fire department connections shall be at least 11?2 in. (38 mm). 6.11.3 Each fire department connection to sprinkler systems shall be designated by a sign having raised or engraved letters at least 1 in. (25.4 mm) in height on plate or fitting reading service design - for example, AUTOSPKR., OPEN SPKR., AND STANDPIPE. 6.11.4 The piping between the check valve and the outside hose coupling shall be equipped with an approved automatic drip in areas subject to	K 351	work order system. Results of this inspection will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice affected seven of seven smoke compartments, staff, and all residents. The facility had the capacity for fifty-three beds with a census of fifty on the day of the survey. K351 (3) □ Sprinkler System □ Installation Compliance date 04/01/2024 Immediate intervention The Director of Plant Operations as contacted sprinkler contractor and scheduled installation of sprinkler protection in the four skylights above the dining room and the two skylights above the Administration lobby. The Director of Plant Operations was educated by the Executive Director on NFPA 13 (2020), 8.5.7 Skylights. The Director of Plant will complete a one-time inspection of the skylights in the LTC facility verifying that these areas are protected by an approved sprinkler system. This inspection will be followed by a semi-annual visual inspection of the skylights. The semi-annual inspection will be uploaded as a task for the facility into the TELS work order system.	

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K 351	Continued From page 6 freezing. Actual NFPA Standard: NFPA 13 (2010), 6.2.7 Escutcheons and Cover Plates. 6.2.7.1 Plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. 6.2.7.2* Escutcheons used with recessed, flush-type, or concealed sprinklers shall be part of a listed sprinkler assembly. Actual NFPA Standard: NFPA 13 (2010), 8.5.7 Skylights. 8.5.7.1 Sprinklers shall be permitted to be omitted from skylights not exceeding 32 ft2 (3 m2) in area, regardless of hazard classification, that are separated by at least 10 ft (3 m) horizontally from any other unprotected skylight or unprotected ceiling pocket. 8.5.7.2 Skylights not exceeding 32 ft2 (3 m2) shall be permitted to have a plastic cover. 8.6.7 Ceiling Pockets (Standard Pendent and Upright Spray Sprinklers). 8.6.7.1* Except as provided in 8.6.7.2 and 8.6.7.3, sprinklers shall be required in all ceiling pockets. 8.6.7.2 Sprinklers shall not be required in ceiling pockets where all of the following are met: (1) The total volume of the unprotected ceiling pocket does not exceed 1000 ft3 (28.3 m3). (2) The depth of the unprotected ceiling pocket does not exceed 36 in. (914 mm). (3) The entire floor under the unprotected ceiling pocket is protected by sprinklers at the lower ceiling elevation. (4)*The total size of all unprotected ceiling pockets in the same compartment within 10 ft (3 m) of each other does not exceed 1000 ft3 (28.3 m3) 8.15.1.2.18.1 Combustible soffits, eaves,	K 351	The results of this inspection will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice affected seven of seven smoke compartments, staff, and all residents. The facility had the capacity for fifty-three beds with a census of fifty on the day of the survey.	

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K 351	Continued From page 7 overhangs, and decorative frame elements shall not exceed 4 ft 0 in. (1.2 m) in width.	K 351		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based observation and interview, it was determined the facility failed to maintain the automatic sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficient practice had the potential to affect two (2) of seven (7) smoke compartments, staff, and forty (40) residents. The facility had the capacity for fifty three (53) beds with a census of fifty (50) on the day of the	K 353	K353 (1) ▫ Sprinkler System ▫ Maintenance and Testing Compliance date 04/01/2024 Immediate intervention The Director of Plant Operations contacted Central Kentucky Sprinkler and had the sprinkler head located in the bathroom room of room 202 and sprinkler head in the oxygen storage room	4/1/24

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K 353	Continued From page 8 survey. The findings include: 1. Observation, during the building inspection tour on 02/08/2024 at 12:01 PM, revealed the sprinkler head located in the bathroom of Room 202 was loaded with paint on the sprinkler head. In an interview on 02/08/2024 at 12:02 PM with the Senior Director of Plant Operations (SDPO), he stated the facility was not aware the sprinkler head was loaded with paint. 2. Observation, during the building inspection tour on 02/08/2024 at 12:06 PM, revealed the sprinkler head located in the oxygen storage room by Room 101 was loaded with paint on the sprinkler head. In an interview on 02/08/2024 at 12:07 PM with the SDPO, he stated the facility was not aware the sprinkler head was loaded with paint. The findings were acknowledged by the Executive Director and verified by the SDPO at the exit interview on 02/08/2024. Actual NFPA Standard: NFPA 101 (2012), 19.3.5 Extinguishment Requirements. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the	K 353	replaced. The Director of Plant Operations was educated by the Executive Director on NFPA 101 (2012), 9.7.5 Maintenance and testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. The Director of Plant will complete a one-time inspection of the sprinkler heads in the LTC facility verifying that these areas are protected by an approved sprinkler system. This inspection will be followed by a semi-annual visual inspection of the sprinkler heads. The semi-annual inspection will be uploaded as a task for the facility into the TELS work order system. The results of this inspection will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice affected seven of seven smoke compartments, staff, and all residents. The facility had the capacity for fifty-three beds with a census of fifty on the day of the survey. K353 (2) □ Sprinkler System ▪ Maintenance and Testing Compliance date 03/05/2024	

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K 353	Continued From page 9 Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Actual NFPA Standard: NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011), 5.2* Inspection. 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).	K 353	Immediate intervention The Director of Plant Operations contacted Central Kentucky Sprinkler and had the sprinkler head located in the oxygen room by room 101 replaced. The Director of the Plant Operations was educated by the Executive Director on Actual NFPA Standard: NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011),5.2* Inspection.5.2.1 Sprinklers.5.2.1.1* Sprinklers shall be inspected from the floor level annually.5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e. upright, pendent, or sidewall). The Director of Plant will complete a one-time inspection of the sprinkler heads in the LTC facility verifying that these areas are protected by an approved sprinkler system. This inspection will be followed by a semi-annual visual inspection of the sprinkler heads. The semi-annual inspection will be uploaded as a task for the facility into the TELS work order system. The results of this inspection will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice had the potential to affect two of seven smoke compartments,	

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K 353	Continued From page 10	K 353	staff, and forty residents. The facility had the capacity for fifty-three beds with a census of fifty on the day of the survey.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers could restrict the transfer of smoke in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice affected seven (7) of seven (7) smoke compartments, staff, and all residents. The facility had the capacity of fifty three (53) beds with a census of fifty (50) on the day of the survey. The findings include: 1. Observation, during the building inspection	K 372	K372 (1)□ Subdivision of Building Spaces □ Smoke Barrier Compliance date 03/05/2024 Immediate intervention The Director of Plant Operations with the assistance of Facilities Management Support installed a wooden walkway in the attic space from the attic access to the smoke barrier located between the 200 Hall and the 600 Hall allowing for safe accessibility to the smoke barrier. The Director of Plant operations was educated by the Executive Director on NFPA 101 (2012), Subdivision of Building	3/5/24

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K 372	Continued From page 11 tour on 02/08/2024 at 10:54 AM, revealed the smoke barrier wall located between the 200 Hall and the 600 Hall was not safely accessible to verify during the inspection of the smoke barriers. In an interview on 02/08/2024 at 10:55 AM with the Senior Director of Plant Operations (SDPO), he stated the facility was unaware of the inaccessibility to safely inspect the smoke barrier. 2. Observation, during the building inspection tour on 02/08/2024 at 11:07 AM, revealed the smoke barrier wall located above the ceiling by the Director of Health Services (DHS) office had a one (1) inch penetration above the sprinkler pipe through the smoke barrier and unsealed drywall seams above the ceiling on the smoke barrier wall that were not sealed to resist the passage of smoke. In an interview on 02/08/2024 at 11:08 AM with the SDPO, he stated the facility was not aware of the penetration or the unsealed drywall joints in the smoke barrier wall. The findings were verified by the SDPO at the time of observation and the Executive Director at the exit conference on 02/08/2024. Actual NFPA Standard: NFPA 101 Life Safety Code (2012), 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1-2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate	K 372	Spaces □ Smoke Barrier Construction. Smoke barriers shall be constructed to a 1□2-hour fire resistance rating per 8.5. The Director will complete a one-time inspection of all smoke barriers to verify that it is safely accessible. The results of this inspection will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice had the potential to affect two of seven smoke compartments, staff, and forty residents. The facility had the capacity for fifty-three beds with a census of fifty on the day of the survey. K372 (2)□ Subdivision of Building Spaces □ Smoke Barrier Compliance date 03/05/2024 Immediate intervention The Director of Plant Operations sealed the 1-inch penetration above the sprinkler pipe through the smoke barrier and the unsealed drywall seams above the ceiling on the smoke barrier wall that were not sealed to resist the passage of smoke with an approved fire caulking. The Director of Plant operations was educated by the Executive Director on NFPA 101 (2012), 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a	

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	185145	A. BUILDING 02 - CEDAR RIDGE HEALTH CAMPUS B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH CAMPUS	1217 US HIGHWAY 62 E CYNTHIANA, KY 41031

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K 372	Continued From page 12 at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2)*Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke.	K 372	smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. The Director of Plant Operations will perform a one-time inspection of all smoke barriers in the facility for penetration and seals. All penetration and seals found deficient during this inspection will be repaired immediately. This on-time inspection will be followed by a semi-annual inspection of the smoke barriers and be uploaded as a task in the facilities work order system TELS. The results of this inspection will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice had the potential to affect two of seven smoke compartments, staff, and forty residents. The facility had the capacity for fifty-three beds with a census of fifty on the day of the survey.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.	K 918		3/5/24

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K 918	Continued From page 13 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to perform testing for the emergency generator in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice affected seven (7) of (7) smoke compartments, staff, and all residents. The facility had the capacity of fifty three (53) beds with a census of fifty (50) on the day of the survey.	K 918	K918 ☐ Electrical Systems ☐ Essential Electric Systems Compliance date 03/05/2024 Immediate intervention The Director of Plant Operations has replaced one of two batteries with a maintenance free battery for emergency generator. The Director of Plant Operations was educated by the Executive Director on	

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K 918	Continued From page 14 The findings include: Record review of the facility's monthly generator logs, for the 12-month period prior to the survey on 02/08/2024 at 11:42 AM revealed that one (1) of the two (2) batteries for the emergency generator for the facility was not maintenance free and was not being tested monthly for electrolyte specific gravity. In an interview with the Senior Director of Plant Operations (SDPO) on 02/08/2024 at 11:43 AM, he stated the facility was unaware that the emergency generator for the facility had any batteries that were not maintenance free. The finding was verified by the SDPO at the time of observation and the Executive Director at the exit conference on 02/08/2024. Actual NFPA Standard: NFPA 110, 8.4 Operational Inspection and Testing. 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.1.1 If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, providing the same record as required by 8.3.4. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:	K 918	NFPA 110, 8.4 Operational Inspection and Testing. 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. The Director of Plant Operations will inspect the emergency generator, two of two batteries for proper maintenance 1 X per week X 6 weeks. The results of this inspection will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice had the potential to affect two of seven smoke compartments, staff, and forty residents. The facility had the capacity for fifty-three beds with a census of fifty on the day of the survey.	

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K 918	Continued From page 15 (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating 8.4.2.1 The date and time of day for required testing shall be decided by the owner, based on facility operations. 8.4.2.2 Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of failure of the primary source. 8.4.2.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours.	K 918		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms	K 920		3/5/24

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K 920	Continued From page 16 (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain extension cords in accordance with National Fire Protection Association (NFPA) standards. The deficient practice affected one (1) of seven (7) smoke compartments, staff, and fourteen (14) residents. The facility had the capacity for fifty (53) beds with a census of fifty (50) on the day of the survey. The findings include: Observation, during the building inspection tour on 02/08/2024 at 12:15 PM, revealed an ungrounded extension cord in use located in resident Room 108. In an interview on 02/08/2024 at 12:16 PM with the Senior Director of Plant Operations (SDPO), he stated the facility was unaware the extension cord was in the resident's room as the facility did not allow extension cords in resident rooms. The finding was verified by the SDPO at the time of observation and the Executive Director at the	K 920	K920 ▯ Electrical Equipment ▯ Power Cords and Extension Cords. Compliance date 03/05/2024 Immediate intervention The Director Plant Operations has removed the ungrounded extension cord in resident room 108. The Director of Plant Operations was educated by the Executive Director on NFPA 99 Health Care Facilities Code (2012) 10.2.4 Adapters and Extension Cords. The Director of Plant Operations has performed a one-time audit of the facility for the use of extension cords and power strips. All unapproved extension cords and power strips will be removed by the Director of Plant Operations during this audit. This one-time audit will be followed with monthly audits of the resident rooms for unapproved extension cords and power strips monthly X 6. The results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations	

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K 920	Continued From page 17 exit conference on 02/08/2024. Actual NFPA Standard: NFPA 99 NFPA 99 Health Care Facilities Code (2012) 10.2.4 Adapters and Extension Cords. 10.2.4.1 Three-prong to two-prong adapters shall not be permitted. 10.2.4.2 Adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. 10.2.4.2.1 All adapters shall be listed for the purpose. 10.2.4.2.2 Attachment plugs and fittings shall be listed for the purpose. 10.2.4.2.3 The cabling shall comply with 10.2.3 10.2.3.2 Grounding Conductor. 10.2.3.2.1 Each electric appliance shall be provided with a grounding conductor in its power cord. Actual NFPA Standard: NFPA 70 National Electrical Code (2011) 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings	K 920	and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice had the potential to affect two of seven smoke compartments, staff, and forty residents. The facility had the capacity for fifty-three beds with a census of fifty on the day of the survey.	