

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365336	(x2) multiple construction a. building <u>BLD 03</u> b. wing _____	(X3) DATE SURVEY COMPLETED 05/19/2026
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name of provider or supplier LOCUST RIDGE HEALTHCARE LLC	street address, city, state, zip code 12745 ELM CORNER ROAD WILLIAMSBURG OH, 45176
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K 0000 BLD03	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY SURVEY REPORT 2012 CODE EXISTING ADMINISTRATOR: Beth Gilmore #7864 CENSUS IN HOUSE: 59</p> <p>BUILDING 1 OF 1</p> <p>42 CFR 483. 90 (a)</p> <p>The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association (NFPA) and the 2012 Edition of the NFPA 99 Healthcare Facilities Code.</p> <p>An annual Life Safety Code Survey was completed on 05/19/26 by the Ohio Department of Health. In this survey, Locust Ridge Healthcare LLC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483. 90 (a), the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, Chapter 19 Existing Health Care Chapter, and the 2012 Edition of the NFPA 99 Healthcare Facilities Code.</p> <p>Locust Ridge Healthcare LLC is a one-story building. The original building, constructed in 1968, was determined to be Type V (000) construction. The original structure is separated from the remaining portion of the facility by a two-hour fire-rated wall and a three-hour fire-rated door. This section does not contain the</p>	K 0000		
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laboratory director's or provider/supplier representative's signature

title

(x6) date

BETH.GILMORE

06/04/2026

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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K 0000	<p>Continued From page 1</p> <p>Skilled Nursing/Nursing Facility (SNF/NF). The additions, which contain the current SNF/NF, were constructed in 1973 and include Rooms #15 to #23 and the physical therapy area. Bedrooms #1 through #14 and #26 through #44 were completed in 1976; the kitchen and activity rooms in 1980; and the main dining room and rooms #46 through #52 in 1998. The SNF/NF building and all additions were determined to be Type II [000] construction and were fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hazardous areas. The facility's Unit Station Four, which includes rooms #41 through #52, is dedicated to residents on life support (ventilators).</p> <p>The facility is a 61-bed Dually Certified nursing home.</p> <p>The requirement at 42 CFR 483. 90 (a) is NOT MET as evidenced by:</p>	K 0000		

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K 0232 K 0232 SS=E BLD03	Continued From page 2 NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to maintain a clear path of egress in accordance with NFPA 101, 2012 Edition sections 19.2.3.4 through 19.2.3.5 and 7.3.2 through 7.3.2.3. This deficient practice had the potential to affect 28 residents residing in the facility and the staff's ability to assist in an emergency. The facility census is 59. Findings include: Observations during facility tours on 05/18/26 and 05/19/26 noted projections into the egress corridor that exceeded allowable limits per code requirements. On 05/18/26, these projections were observed in the following locations and times. At approximately 1:33 P.M. in	K 0232 K 0232	This Plan of Correction is submitted as required under State and Federal law. This Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's policies and procedures should be subsequent remedial measures and should be inadmissible in any proceeding on that basis. Without admitting or denying the validity or the existence of the alleged noncompliance, the Facility submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or other action against the facility or any employee, agent, officer, director or shareholder of the Facility. The Facility is utilizing this Plan of Correction as its allegation of substantial compliance as of 05/29/2026 K-0232 Clear path of egress Corrective action for resident/s: 1. On 05/18/2026 station 3 had a cart with a television parked in the corridor by room 38 that exceeded allowable limits. Maintenance director/designee moved the TV cart into the activity room, out to the corridor on 05/18/2026 in accordance with applicable code. 2. On 5/18/2026 station 3 had 5 chairs in the corridor near the dining room directly in front of the fire extinguisher. Maintenance director/designee moved the chairs into the dining room, out of the corridor on 5/18/2026 in accordance with applicable code. 3. On 5/19/2026 station 3 had 4 chairs by the activity room and 4 by room 35. In addition, the TV cart was in the corridor. The maintenance	05/29/2026

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K 0232	<p>Continued From page 3</p> <p>Station #3, a cart with a television and video equipment was plugged into an outlet in the corridor by room 38. At approximately 1:42 P.M., five activity room chairs were in the corridor near the secured unit dining room, directly in front of the fire extinguisher. On 05/19/26 at approximately 8:15 A.M., there were chairs in the corridor in Station #3, four by room 35 and four by the activities room, and the television cart was still in the corridor. The chairs were not secured. The corridor was approximately eight feet wide, and the projections were approximately 29 inches and in front of the handrail.</p> <p>An interview with the Maintenance Director at the time of discovery confirmed these findings.</p>	K 0232	<p>director/designee moved the chairs and TV cart into the dining room, out of the corridor on 5/19/2026 in accordance with applicable code. Identification of other residents who may be affected: Maintenance</p> <p>director/designee completed a 100% facility audit for clear paths of egress on 5/26/26 with no findings or corrective action necessary.</p> <p>Measures for systemic change: Maintenance Director/designee educated staff on 5/26/2026 regarding NFPA 101-2012 section 19.2.3.4 and 19.2.3.5 specifically including maintaining a clear path of egress. How Corrective Action will be monitored Ongoing "Path of Egress Audit" to be completed weekly x 2 weeks, then monthly x 2 months. Corrective action will be initiated for any noted non-compliance. Audit findings will be reviewed as part of the monthly quality assurance process to determine the need for further monitoring. Date of Compliance 05/29/2026</p>	
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K 0321	<p>Continued From page 5</p> <p>e. Trash Collection Rooms (exceeding 64 gallons)</p> <p>f. Combustible Storage Rooms/Spaces (over 50 square feet)</p> <p>g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to ensure protection from hazardous areas in accordance with NFPA 101, 2012 Edition sections 19.3.2 through 19.3.2.1.5, 6.2 through 6.2.2.3, 8.4.3.5, and 7.2.1.8 through 7.2.1.8.2(4). This deficient practice had the potential to affect all residents and staff's ability to assist in an emergency. The Facility census was 59.</p> <p>Findings include:</p> <p>Observations during tours of the facility on 05/18/26, between 12:15 P.M. and 2:15 P.M., it was noted that hazardous areas were not maintained in accordance with applicable code requirements. The facility lacked self-closing or automatic-closing doors to hazardous storage areas. These rooms, used for storage without self-closing doors, were observed in the</p>	K 0321	<p>area on station 3 was lacking a self-closing door on 5/19/2026. Maintenance director to add a self-closing door to the smoking area on station 3 on or before 06/12/2026 in accordance with applicable code. 5. The housekeeping room across from therapy was lacking a self-closing door on 5/19/2026. Maintenance director to add a self-closing door to the housekeeping room across from therapy gym on or before 06/12/2026 in accordance with applicable code. 6. The lobby storage room was lacking a self-closing door on 5/19/2026. Maintenance director to add a self-closing door to the lobby storage room on or before 06/12/2026 in accordance with applicable code. Identification of other residents who may be affected: LNHA and Maintenance director/designee completed a full facility audit for doors with self-closing devices on 05/26/2026. Any corrective action, including, doors identified as needed self-closures will be added on or before 06/09/2026 in accordance with applicable code. Measures for systemic change: LNHA educated Maintenance Director on 05/26/2026 regarding NFPA 101-2012 sections 19.3.2.1 and 19.3.5.9 specifically regarding doors with self-closing devices. How Corrective Action will be monitored Ongoing "Doors with Self-Closing device audit" to be completed weekly x 2 weeks, then monthly x 2 months. Corrective action will be initiated for any noted non-compliance. Audit findings will be reviewed as part of the monthly quality assurance process to determine the need for further monitoring. Date of Compliance 06/12/2026</p>	

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K 0321	Continued From page 6 following areas: the closet next to medical records, the beauty salon used to store cases of chemicals, the supply room in Station #2, and the room to the smoking area in Station #3, the Unit. On 05/19/26, additional hazardous areas were observed during a tour of the facility at approximately 8:04 A.M. The housekeeping room across from therapy did not have a self-closing door, and at approximately 8:09 A.M., the lobby storage room did not have a self-closing door. These findings were verified by the Maintenance Director at the time of discovery.	K 0321		

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K 0712 K 0712 SS=F BLD03	Continued From page 7 NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on the record review and staff interview, the facility failed to ensure that fire drills were conducted in accordance with NFPA 101, 2012 Edition, sections 19.7.1 through 19.7.1.8. This deficient practice had the potential to affect all the residents in the facility and the staff's ability to assist in an emergency. The facility census was 59. Findings include: The record review on 06/09/25, at approximately 10:32 A.M., noted that fire drills were not conducted every shift each quarter and were not conducted under varied conditions. There were no records of a fire drill for the first shift during the	K 0712 K 0712	This Plan of Correction is submitted as required under State and Federal law. This Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's policies and procedures should be subsequent remedial measures and should be inadmissible in any proceeding on that basis. Without admitting or denying the validity or the existence of the alleged noncompliance, the Facility submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or other action against the facility or any employee, agent, officer, director or shareholder of the Facility. The Facility is utilizing this Plan of Correction as its allegation of substantial compliance as of 05/29/2026 K-0712 Fire Drills Corrective action for resident/s: There were no records of a fire drill for the first shift of the third quarter of 2025. First shift fire drill completed on 5/24/2026 by maintenance director/designee with no findings or corrective action necessary. Identification of other residents who may be affected: On 5/26/2026 Maintenance director/designee completed 100% audit of the scheduled fire drills to ensure a drill is scheduled quarterly each shift with no findings or corrective action necessary. Measures for systemic change: LNHA educated Maintenance Director on 05/26/2026 regarding NFPA 101-2012 section 19.7.1.4 through 19.7.1.7. specifically including fire drill frequency requirements.	05/29/2026

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K 0712	Continued From page 8 third quarter. The records showed that fire drills on the first shift were conducted on 01/30/26 at 2:42 P.M., 04/30/26 at 1:51 P.M., and 10/31/25 at 10:58 A.M. The records showed that fire drills on the second shift were conducted on 02/26/26 at 5:20 P.M., 06/03/25 at 4:35 P.M., 08/29/25 at 3:46 P.M., and 11/25/25 at 5:09 P.M. The records showed that fire drills on the third shift were conducted on 03/30/26 at 11:47 P.M., 05/30/25 at 12:18 A.M., 07/22/25 at 11:34 P.M., 09/26/25 at 11:40 P.M., and 12/15/25 at 5:17 A.M. The Maintenance Director confirmed these findings at the time they were discovered.	K 0712	How Corrective Action will be monitored Ongoing "Fire Drill Audit" to be completed weekly x 2 weeks, then monthly x 2 months. Corrective action will be initiated for any noted non-compliance. Audit findings will be reviewed as part of the monthly quality assurance process to determine the need for further monitoring. Date of Compliance 05/29/2026	