PRINTED: 03/28/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039
	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/05/2024	
	PROVIDER OR SUPPLIES		705 E	ADDRESS, CITY, STATE, ZIP COD MAIN ST ERVILLE, IN 47330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
E 0000 Bldg	conducted by the In accordance with 42 Survey Date: 03/05 Facility Number: 02 Provider Number: AIM Number: 100 At this Emergency	5/24 000456 155490	E 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general or this corrective action in particular, does not constitute a admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance	al, an s	
	compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 137 certified beds. At the time of the survey, the census was 93. Quality Review completed on 03/06/24			with state and federal laws. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after March 14, 2024.		
E 0004 SS=C Bldg	484.102(a), 485.6 485.727(a), 485.9 491.12(a), 494.62 Develop EP Plan Annually §403.748(a), §41 §441.184(a), §46 §483.73(a), §483 §485.68(a), §485	5(a), 483.475(a), 483.73(a), 625(a), 485.68(a), 920(a), 486.360(a),				

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

The [facility] must comply with all applicable

TITLE (X6) DATE

Jared Glaub **Executive Director** 03/27/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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` '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/05/2024	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION DATE
	Federal, State and preparedness required must develop estate comprehensive errorgram that mee section. The emer program must include the following eleminated at least must do all of the section of the section and updated at least must do all of the section of t	d local emergency uirements. The [facility] ablish and maintain a mergency preparedness ts the requirements of this regency preparedness ude, but not be limited to, rents: an. The [facility] must tain an emergency that must be [reviewed], rest every 2 years. The plan following: §482.15 and CAHs at regency Plan. The [hospital reply with all applicable d local emergency uirements. The [hospital or rep and maintain a mergency preparedness ts the requirements of this n all-hazards approach. res at §483.73(a):] The LTC facility must tain an emergency that must be reviewed, rest annually. rities at §494.62(a):] The ESRD facility must tain an emergency that must be [evaluated], rest every 2 years.				
	Based on record rev	view and interview, the facility	E 0004	1 What corrective action(s) will	03/19/2024

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failed to review and update the Emergency

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be accomplished for those

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155490		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/05/2024		
	PROVIDER OR SUPPLIER		STREE 705 E CEN			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG	Preparedness Plan (accordance with 42 practice could affect Findings include: Based on records re Administrator and to 03/05/24 between 1 EEP cover page did which was current, indicated on the covother date could be reviewed and update. This finding was ac Administrator and Management of the covother date could be reviewed and update.	EPP) at least annually in CFR 483.73(a). This deficient t all occupants. view and interview with the he Maintenance Director on 0:00 a.m. and 12:45 p.m., the not have an annual update The last update to the EPP ver page was 01/11/23 and no found to show the EPP was ed within the last year.	TAG	residents found to have beer affected by the deficient prace Emergency Preparedner Plan was reviewed on March 2024 and follow up on March 2024 2 How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken All residents have the potential to be affected by the alleged deficient practice. 3 What measures will be into place and what systemic changes will be made to ensithat the deficient practice docrecur EPP will be scheduled reviewed each year as a part QAPI. Current EPP has bee reviewed and updated on March 28, 2024 How the corrective action will be monitored to ensure the deficient practice will not receive., what quality assurance program will be put into place QAPI committee will reference program will be put into place QAPI committee will reference program to program to place QAPI committee will reference program will be put into place QAPI committee will reference program will be put into place QAPI committee will reference program will be put into place QAPI committee will reference program will be put into place QAPI committee will reference program will be put into place quality and place program will be put into place program will be put into place program will be put into place p	tice ess 19, 28, ving y the e e to to be to be to of n troch e 4. on(s) ne ur, e view as nic will	
	1		ı	Sheet	ı	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155490		A. Bl	A. BUILDING COM			survey Leted /2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
E 0013 SS=C Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §466 §483.73(b), §485. §485.68(b), §485. §485.920(b), §486 §494.62(b). (b) Policies and produced preparedness policy on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policy be reviewed and unyears. *[For LTC facilities and procedures. To develop and impless preparedness policy on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policy on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policy be reviewed and unwell the proparedness policy on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policy be reviewed and unwell the propagation of the policy be reviewed and unwell the policy be reviewed and unwell the propagation of the policy between the propagation of the policy be reviewed and unwell the propagation of the policy be reviewed and unwell the propagation of the policy between the propagation of the policy between the propagation of the propagati	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 2.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 6.360(b), §491.12(b), 5.360(b), 5.360(b					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED	
		155490	B. WING		03/05/2024	
	PROVIDER OR SUPPLIER		705 E	ADDRESS, CITY, STATE, ZIP COD MAIN ST		
AIVIBASS	ADOR HEALTHCA	NE .	CENT	ERVILLE, IN 47330		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The polician address manager nonmedical emergilimited to: Fire; eq failure; care-related disasters likely to safety of the partic. The policies and previewed and upd. *[For ESRD Facility and procedures. develop and imple preparedness policy on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policies	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must ment of medical and gencies, including, but not uipment, power, or water and emergencies; and natural threaten the health or cipants, staff, or the public. Procedures must be ated at least every 2 years.				
	not limited to, fire, failures, care-relat supply interruptior likely to occur in th	rgencies include, but are equipment or power ed emergencies, water n, and natural disasters ne facility's geographic				
	failed to review and Preparedness Plan's at least annually in	view and interview, the facility lupdate the Emergency (EPP) Policies and Procedures accordance with 42 CFR cient practice could affect all	E 0013	What corrective action(s) be accomplished for those residents found to have been affected by the deficient pract Emergency Preparedne Plan is scheduled has been reviewed on March 19, 2024 a	ice ss	

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Findings include:

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follow up will be on March 28,

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155490		(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED 03/05/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPR	LD BE COMPLETION		
	Administrator and to 03/05/24 between 1 EEP cover page did which was current. indicated on the covother date could be and Procedures was the last year. This finding was ac Administrator and Mitime of discovery and the covoring of the covoring the covo	Maintenance Director at the and again at the exit conference.		2024 2 How other residents the potential to be affected same deficient practice widentified and what correct action(s) will be taken All residents have the potential to be affected by alleged deficient practice. 3 What measures will into place and what system changes will be made to that the deficient practice recur EPP will be schedulareviewed each year as a QAPI. Current EPP has be reviewed and updated on 19, 2024 and follow up convill be on March 28, 2024. How the corrective a will be monitored to ensure deficient practice will not i.e., what quality assurance program will be put into put int	ad by the rill be citive the		
E 0029 SS=C Bldg	403.748(c), 416.54 441.184(c), 482.14 484.102(c), 485.64 485.727(c), 485.94	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c),					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155490		A. BUII	A. BUILDING <u></u>			COMPLETED 03/05/2024	
	PROVIDER OR SUPPLIES	R	STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	§403.748(c), §411 §441.184(c), §461 §483.73(c), §483 §485.68(c), §485 §485.920(c), §486 §494.62(c). (c) The [facility] man emergency proplemental that complies local laws and must least every 2 yellocal laws and with least every 2 yellocal laws and upda Preparedness Plantelses annually in action 483.73(a). This deformation occupants. Findings include: Based on records mand 03/05/24 between the EEP cover page did which was current. Indicated on the coother date could be Communication Players within the last year. This finding was action and the second properties of the second p	Communication Plan 3.54(c), §418.113(c), 0.84(c), §482.15(c), 475(c), §484.102(c), 625(c), §485.727(c), 6.360(c), §491.12(c), bust develop and maintain reparedness communication is with Federal, State and updated rears [annually for LTC] wiew and interview, the failed rete the Emergency is (EPP) Communication Plan at cordance with 42 CFR received and affect all eview and interview with the the Maintenance Director on 10:00 a.m. and 12:45 p.m., the dinot have an annual update The last update to the EPP ver page was 01/11/23 and no found to show EPP's an was reviewed and updated	E 002	29	1 What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice. Emergency Preparedness Plan, including the Communication Plan, is scheduled has been reviewed March 19, 2024 and follow up be on March 28, 2024 2 How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken All residents have the potential to be affected by the alleged deficient practice. 3 What measures will be printo place and what systemic changes will be made to ensurthat the deficient practice does recur EPP will be scheduled to reviewed each year as a part of the second se	on will ang the the service of the color of	03/19/2024

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155490		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 03/05/2024			ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0036 SS=C Bldg	484.102(d), 485.6. 485.727(d), 485.9. 491.12(d), 494.62 EP Training and T §403.748(d), §416. §441.184(d), §460. §485.68(d), §485. §485.920(d), §486. §494.62(d). *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625. 485.727, CMHCs	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d)			QAPI. Current EPP has been reviewed and updated on Mar 19, 2024 and follow up will be completed on March 28, 2024 4 How the corrective action will be monitored to ensure the deficient practice will not recurive., what quality assurance program will be put into place QAPI committee will reven EPP on an annual basis and an eneded. 5 By what date the system changes for each deficiency will be completed March 19, 2024 Enclosures: PDF – E029 Signature Sheet	n(s) eerr, iew	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155490		A. BUILDING B. WING		COMPLETED 03/05/2024		
NAME O	F PROVIDER OR SUPPLIEI			ADDRESS, CITY, STATE, ZIP COD MAIN ST		
AMBA	SSADOR HEALTHCA	.RE		ERVILLE, IN 47330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	UMMARY STATEMENT OF DEFICIENCIE DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	Training and testing develop and main preparedness train that is based on the in paragraph (a) consistent as escential assessment at passessment at passessm	ng. The [facility] must tain an emergency ning and testing program ne emergency plan set forth of this section, risk ragraph (a)(1) of this and procedures at paragraph and the communication (c) of this section. The g program must be lated at least every 2 years. Se at §483.73(d):] (d) Training LTC facility must develop emergency preparedness g program that is based on an set forth in paragraph (a) k assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this hing and testing program and updated at least \$483.475(d):] Training and lD must develop and gency preparedness training am that is based on the leet forth in paragraph (a) of lessessment at paragraph (b) of this section, and the leet forth in paragraph (c) of this lessessment at paragraph (d) of lessessment at paragraph (e) of this length and testing program and updated at least every	TAG			

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155490		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330			
(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	
	Training, testing, a dialysis facility mu emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) or procedures at parand the communic of this section. The orientation prograupdated at every 2 Based on record reviewed and Preparedness Plan's Plan at least annual 483.73(a). This definition occupants. Findings include: Based on records reviewed and to 3/05/24 between 1 EEP cover page did which was current, indicated on the covother date could be Training and Testin updated within the later than the finding was ac Administrator and Market and State of the covother date within the later than the finding was ac Administrator and Market and State of the covother date within the later than the state of the covother date within the later than the state of the covother date within the later than the state of the covother date within the later than the state of the covother date within the later than the state of the covother date within the later than the state of the covother date and the covoth	view and interview, the facility updated the Emergency (EPP) Training and Testing by in accordance with 42 CFR cient practice could affect all view and interview with the he Maintenance Director on 0:00 a.m. and 12:45 p.m., the not have an annual update The last update to the EPP ver page was 01/11/23 and no found to show the EPP's g Plan was reviewed and ast year.	E 0036	1 What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice. Emergency Preparedness Plan, including the Training and Testing Policy, has been revied on March 19, 2024 and follow will be on March 28, 2024 2 How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken All residents have the potential to be affected by the alleged deficient practice. 3 What measures will be printo place and what systemic changes will be made to ensure that the deficient practice does recur EPP will be scheduled to reviewed each year as a part of QAPI. Current EPP has been reviewed and updated on Mar 19, 2024 and follow up will be	ce ss ad wed up ng the ut re s not be of	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/05/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE			
				completed on March 28, 2 4 How the corrective a will be monitored to ensur deficient practice will not i.e., what quality assurant program will be put into p QAPI committee will EPP on an annual basis a needed. 5 By what date the syschanges for each deficient be completed March 19, 2024 Enclosures: PDF - E036 Signate Sheet	action(s) re the recur, ce lace I review and as stemic ncy will		
K 0000 Bldg. 01							
Blug. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 03/05 Facility Number: 0 Provider Number: 100 At this Life Safety 0 Healthcare was four Requirements for Pa Medicare/Medicaid Life Safety from Fir National Fire Protect	288750 Code survey, Ambassador and not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the cition Association (NFPA) 101, and SC) Chapter 19, Existing Health	K 0000	DISCLAIMER STATEMENT Preparation and/or executhis plan of correction in gor this corrective action in particular, does not constadmission or agreement to facility of the facts alleged conclusions set forth in the statement of deficiencies. plan of correction and specorrective actions are preand/or executed in complewith state and federal law provider respectfully required this 2567 Plan of Correctic considered the Letter of Callegation of Compliance requests a desk review in post survey review on or a March 14, 2024.	tion of general, of itute an opy this of or		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155490		A. BUILDING 01 B. WING			COMPLETED 03/05/2024		
	ROVIDER OR SUPPLIER ADOR HEALTHCA		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX CROS TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0211 SS=E Bldg. 01	consists of four attact a one-story building through 120 and Ro two-story section of partial basement. Building consisting Building 03 consists and is a one-story be basement. Building consisting of Rooms 302 through 313. E and was determined construction and was The facility has a find detection in the correction and on all 1 basement in the west facility has battery or resident sleeping roccapacity of 137 and of this visit. All areas where resilied and a services were sprinkled and a services were sprinkled and services were	General General ays, corridors, exit cations, and accesses are n Chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155490	B. W	ING		03/05/2024	
			<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	£			MAIN ST		
AMRASS	ADOR HEALTHCA	RF			RVILLE, IN 47330		
	, LOTTILALITION						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	18.2.1, 19.2.1, 7.1						
		on and interview, the facility	K 0	211	1 What corrective action(s)	will	03/11/2024
		f over 10 means of egress was			be accomplished for those		
	-	ained free of all obstructions			residents found to have been		
	-	full instant use in the case of			affected by the deficient practi		
	_	ency. This deficient practice			Door leading to the outsi		
		residents, staff and visitors if			sitting area is no longer marke		
	needing to exit the	dialysis area.			an "exit" door and signage has		
	E' 1' ' 1 1				been removed. The desk was		
	Findings include:				removed from the dialysis den	as	
	D 1 1	at a state			well.		
		on and interview with the			2 How other residents havi	-	
		for (MD) and Administrator on			the potential to be affected by		
		2:45p.m. and 3:15 p.m., the exit			same deficient practice will be		
		dialysis unit, marked a facility			identified and what corrective		
		l inside the door with carts and			action(s) will be taken.		
		ng computers. The MD stated			All residents that utilize t		
	-	moved the equipment near the			dialysis den have the potential		
		ne dialysis unit was very full			be affected by the alleged defi		
	and busy and there around.	isn't a lot of room to move			practice. A walk through of the		
	around.				facility was completed to ensu no other exits were affected. N		
	Each of the two pet	hs of egress was marked as a				NO	
	-	exit sign. Based on interview			further issues were found.	.4	
	-	exit sign. Based on interview oservations, the Maintenance			3 What measures will be pu	ut	
		he aforementioned means of			into place and what systemic changes will be made to ensur	ro	
		inuously maintained free of all			that the deficient practice does		
		ediments to full instant use in			· ·	5 1101	
	the case of fire or or				recur. Maintenance to observe	avit	
	the case of fire of o	mer emergency.			egress to ensure there are no	CAIL	
	This finding was ac	knowledged by the			impediments.		
	_	Maintenance Director at the			4 How the corrective action	n(s)	
		nd again at the exit conference.			will be monitored to ensure the		
	or albeovery un	and the same contention.			deficient practice will not recur		
	3.1-19(b)				i.e., what quality assurance	,	
	(-)				program will be put into place.		
					Maintenance Director, or		
					designee, will ensure that mea		
					of egress will be continuously		
					maintained free of impediment	ts	
			1		I		

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	F OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	ľ	UILDING	ONSTRUCTION 01	(X3) DATE COMPI 03/05	LETED
	PROVIDER OR SUPPLIE			705 E N	ADDRESS, CITY, STATE, ZIP COD MAIN ST ERVILLE, IN 47330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0324 SS=E Bldg. 01	Ventilation Control Commercial Cool * residential cook appliances such a toasters) are used cooking in accord 19.3.2.5.2 * cooking facilities smoke compartm patients comply v 18.3.2.5.3, 19.3.2	ent is protected in NFPA 96, Standard for ol and Fire Protection of king Operations, unless: ing equipment (i.e., small as microwaves, hot plates, d for food warming or limited lance with 18.3.2.5.2, s open to the corridor in ents with 30 or fewer vith the conditions under			during daily rounds. Any deficiencies will be discussed monthly as part of the Quality Assurance and Performance Improvement (QAPI) meeting. 5 By what date the systemichanges for each deficiency who is completed. 03/11/2024 Enclosures: PDF - Floor Plan - East Exits (2) Picture - K211 - Desk S	ic rill Fire Fire	

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with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not

18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1

be open to the corridor.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155490	B. W			03/05/	
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEF	₹			MAIN ST		
AMBASS	ADOR HEALTHCA	RE			RVILLE, IN 47330		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	through 19.3.2.5.5	5, 9.2.3, TIA 12-2					
	•	on and interview, the facility	K 0	324	1 What corrective action(s)	will	03/11/2024
	failed to ensure 1 or	f 1 Ansul (pull stations) were	"		be accomplished for those		
	not obstructed. NF	PA 96, Section 10.5.1 states a			residents found to have been		
	readily accessible n	neans for manual activation			affected by the deficient practi	ce	
	shall be accessible	in the event of a fire. This			The large trash receptad		
	deficient practice co	ould affect 4 staff in the			that was parked in front of the		
	kitchen.				station for the Ansul system w	-	
					removed from the area. All tra		
	Findings include:				receptacles are to have wheel	s	
					underneath to easily move wh	en	
	Based on observation	on and interview with the			necessary.		
		tor and Administrator on			2 How other residents havi	ng	
	03/05/24 between 1	2:45p.m. and 3:15 p.m., the pull			the potential to be affected by	the	
	station for the hood	Ansul system in the kitchen			same deficient practice will be	:	
	had a large trash red	ceptacle parked in front of the			identified and what corrective		
	_	ting access. Based on			action(s) will be taken.		
		es of observation, the			All kitchen staff have the	:	
		tor agreed the cart was			potential to be affected by the		
	blocking the pull st	ation.			alleged deficient practice. A		
					walkthrough of the kitchen wa		
	This finding was ac				completed to ensure no other		
		Maintenance Director at the			impediments were in place. N	lo	
	time of discovery a	nd again at the exit conference.			further issues were found.		
					3 What measures will be p	ut	
	3.1-19(b)				into place and what systemic		
					changes will be made to ensu		
					that the deficient practice does	s not	
					recur.	_4	
					Dietary staff educated th		
					there are to be no items place	u III	
					front of Ansul pull stations. Observations to be completed	to	
					ensure there are no Ansul pull		
					station impediments.	ı	
					4 How the corrective action	n(e)	
					will be monitored to ensure the	` '	
					deficient practice will not recui		
					i.e., what quality assurance	,	
					program will be put into place.		
			1		I Program will be put little place.		I

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155490	B. W	ING		03/05/	/2024
	PROVIDER OR SUPPLIE			705 E N	ADDRESS, CITY, STATE, ZIP COD MAIN ST ERVILLE, IN 47330	<u>, </u>	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	,,,,,	DATE
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric National Fire Alar Records of system and testing are respected in the National Fire Alar Records of system and testing are respected in the National Parameters of the National Param	m - Testing and em is tested and maintained th an approved program the requirements of NFPA 70, Code, and NFPA 72, em and Signaling Code. Em acceptance, maintenance the endity available. NFPA 70, NFPA 72 view and interview, the facility and of 1 fire alarm systems in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section inless otherwise permitted by	K 0	345	Dietary Manager, or designee, will round daily to ensure that Ansul pull station impediments are not occurrin Any deficiencies will be discurrently as part of the Quality Assurance and Performance Improvement (QAPI) meeting 5 By what date the system changes for each deficiency be completed 03/11/20024 Enclosures: Picture – K324 – Ansul Station 1 What corrective action(station) be accomplished for those residents found to have been affected by the deficient practice. Koorsen Fire & Security was contacted to schedule the	ng. ussed y g. nic will Pull s) will tice y	03/22/2024
	14.3.2, visual inspeace accordance with the	nless otherwise permitted by ections shall be performed in e schedules in Table 14.3.1, or red by the authority having			Koorsen Fire & Security was contacted to schedule the visual semi-annual fire alarm system inspection. This	ne	

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jurisdiction. Table 14.3.1 states that the following

must be visually inspected semi-annually:

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inspection will be completed on

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PARTMENT OF HEALTH AND HU NTERS FOR MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/05/2024
NAME OF PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
AMBASSADOR HEALTHCA	ARE		MAIN ST RVILLE, IN 47330	
PREFIX (EACH DEFICIEN	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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
a. Control unit troub. Remote annuncic. Initiating devices fire alarm boxes, hetc.) d. Notification apperent e. Magnetic hold-on This deficient practoccupants. Findings include: Based on records readministrator and 03/05/24 between documentation was regarding a visual sinspection. This finding was as Administrator and	able signals ators s (e.g. duct detectors, manual eat detectors, smoke detectors,	IAU	2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by the alleged deficient practice. The scheduled visual inspection with Koorsen will put facility in compliance with this regulation 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does recur. Repetitive tasks will be entered into TELS to track semi-annual completion of the visual fire alarm inspection. 4 How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Maintenance Director, or designee, will verify semi-annut TELS task are completed and reports are received from contracted vendor. Any deficiencies will be discussed	the the state of t

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be completed

Enclosures:

03/22/2024

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PDF - 03/22/2024 Koorsen

monthly as part of the Quality Assurance and Performance Improvement (QAPI) meeting. By what date the systemic changes for each deficiency will

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	HEALTH AND HUN DICARE & MEDIC.					RM APPROVED IB NO. 0938-039		
	F DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE COMPI 03/05	SURVEY LETED		
	TIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST					
AMBASSAD	OR HEALTHCA	RE	CENTERVILLE, IN 47330					
(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)	ATE	(X5) COMPLETION DATE		
SS=E Bldg. 01 Sp 20 Nu by thi sp 13 Sy In pr su ar sp In clo wh 6 s the St Sy 19 19 Ba fai pr Th sta Fi	roughout by an arinkler system in a system in a standard for the state of the state		K 0351	1 What corrective action(s be accomplished for those residents found to have been affected by the deficient pract Sprinkler pendants were installed by the contracted ve 2 How other residents hav the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken	ice ndor. ing the	03/19/2024		

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Soiled Utility and Kitchenette in the West

building did not have sprinkler coverage. The MD

stated that the two rooms had a pipe leak in the

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13 residents and employees

have the potential to be affected

by the alleged deficient practice.

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE : COMPL 03/05/	ETED
	PROVIDER OR SUPPLIER		705 E I	ADDRESS, CITY, STATE, ZIP COD MAIN ST ERVILLE, IN 47330		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ers and were removed. The	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY) Employees have access to	D BE OPRIATE	(X5) COMPLETION DATE
	facility was waiting replacements for the aforemention sprinklers were in put time of observation aforementioned rocautomatic extinguis. This finding was act Administrator and I time of discovery at 3.1-19(b)			Employees have access to the soiled utility and kitche areas to monitor for the prof smoke and/or fire. Fire extinguishers are posted in rooms for use in case of emergency. Custom sprint pendants were installed 03/19/2024. 3 What measures will be into place and what system changes will be made to eat the deficient practice of the recur and the deficient practice of the the deficient practice of the completed by contractions are entered quality assurance program will be monitored to ensure deficient practice will not refine, what quality assurance program will be put into plate Maintenance Director designee, will verify the prof all sprinkler pendants. Supplementation of the program is inspected quarter contracted vendor to ensure operation. Any deficiencied discussed monthly as part Quality Assurance and Performance Improvementating. 5 By what date the systic changes for each deficiency be completed 03/19/2024	enette esence In both likler De put mic Insure does not kler Larterly cted Ction(s) e the ecur, e ace Dr, or esence Sprinkler erly by re proper es will be it (QAPI) temic	
K 0353 SS=E	NFPA 101 Sprinkler System	- Maintenance and Testing				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/05/2024
	PROVIDER OR SUPPLIER		705 E I	ADDRESS, CITY, STATE, ZIP COD MAIN ST ERVILLE, IN 47330	
(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. 01	Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location are a) Date sprinkler b) Who provided c) Water system Provide in REMAF coverage for any reautomatic sprinkle 9.7.5, 9.7.7, 9.7.8. Based on observation failed to maintain the storage room. The cogases around the special to operate at a special composition of the sprinkler deflects be selected based on type of construction affects 5 residents. Findings include: Based on observation affects 5 residents. Findings include: Based on observation affects 5 residents. This finding was according tiles were maroom.	supply source RKS information on non-required or partial or system. and NFPA 25 on and interview, the facility ne ceiling construction of one reciling tiles trap hot air and rinkler and cause the sprinkler fied temperature. NFPA 13, 11 states the distance between for and the ceiling above shall in the type of sprinkler and the in. This deficient practice on and interview with the for (MD) and Administrator on 2:45p.m. and 3:15 p.m., Multiple issing in the Dialysis storage	K 0353	1 What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice. Ceiling tiles were replaced in the storage room. 2 How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken 6 residents have the potential to be affected by the alleged deficient practice. All ceiling tiles in storage areas an place currently. 3 What measures will be positive processes and the potential to be affected by the alleged deficient practice. All ceiling tiles in storage areas and place currently. 3 What measures will be positive practice and what systemic changes will be made to ensure that the deficient practice does recur	re in ut

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/05/2024
	PROVIDER OR SUPPLIER		705 E	ADDRESS, CITY, STATE, ZIP COD MAIN ST ERVILLE, IN 47330	
(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
	time of discovery at 3.1-19(b)	nd again at the exit conference.		A weekly TELS task to ensure all ceiling tiles are in p in storage areas was added 4 How the corrective action will be monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place Maintenance Director, or designee, to complete TELS to weekly to ensure proper placement of ceiling tiles in storage areas. Any deficiencie will be discussed monthly as not the Quality Assurance and Performance Improvement (Comeeting. 5 By what date the system changes for each deficiency will be completed 03/19/2024 Enclosures: Picture – K353 – Ceiling Tiles (1) Picture – K353 – Ceiling Tiles (2) Picture – K353 – Ceiling Tiles (3)	n(s) e r, r ask es part tAPI) ic vill
K 0355 SS=E Bldg. 01	installed, inspecte	nguishers guishers are selected, d, and maintained in IFPA 10, Standard for nguishers.			
	failed to ensure 1 of	on and interview, the facility f over 10 portable fire not obstructed in accordance	K 0355	What corrective action(s be accomplished for those residents found to have been	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED
		155490	B. WIN	NG		03/05/2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIE	R			MAIN ST	
AMDACC		A D.E.				
AMBASS	SADOR HEALTHC	ARE		CENTE	ERVILLE, IN 47330	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE
	with NFPA 10, Sta	andard for Portable Fire			affected by the deficient practi	ice
	Extinguishers, 201	0 Edition. Section 6.1.3.3 states			The large trash receptad	cle
	Fire extinguishers	shall be conspicuously located			that was parked in front of the	
	where they are rea	dily accessible and immediately			K-Class fire extinguisher was	
	available in the eve	ent of fire. This deficient			removed from the area. All tra	ash
	practice could affe	ct 4 staff in the kitchen area.			receptacles are to have wheel	s
					underneath to easily move wh	en
	Findings include:				necessary.	
					2 How other residents havi	ng
	Based on observat	ion and interview with the			the potential to be affected by	the
	Maintenance Direc	ctor and Administrator on			same deficient practice will be	
	03/05/24 between	12:45p.m. and 3:15 p.m., the			identified and what corrective	
	K-Class fire exting	guisher located in the kitchen			action(s) will be taken	
	was blocked by a l	arge trash receptacle.			All kitchen staff have the	;
					potential to be affected by the	
	This finding was a	cknowledged by the			alleged deficient practice. A	
	Administrator and	Maintenance Director at the			walkthrough of the kitchen wa	s
	time of discovery	and again at the exit conference.			completed to ensure no other	
					impediments were in place. N	lo
	3.1-19(b)				further issues were found.	
					3 What measures will be p	ut
					into place and what systemic	
					changes will be made to ensu	re
					that the deficient practice does	s not
					recur	
					Dietary staff educated th	
					there are to be no items place	
					front of K-Class fire extinguish	
					Observations to be completed	
					ensure there are no K-Class f	ire
					extinguishers impediments.	
					4 How the corrective action	` '
					will be monitored to ensure the	
					deficient practice will not recu	r,
					i.e., what quality assurance	
					program will be put into place	
					Dietary Manager, or	
					designee, will round daily to	
					ensure that K-Class fire	
					extinguishers impediments are	e not

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DEPARTMENT OF HEALTH AND HUN	MAN SERVICES		
CENTERS FOR MEDICARE & MEDICA	AID SERVICES		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X

AND PLAN	OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIES SADOR HEALTHCA		A. BUILDING DO A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330 ENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECT		(X3) DATE SURVEY COMPLETED 03/05/2024
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
K 0761 SS=E Bldg. 01	Based on observati interview, the facil inspection and testi assemblies were considered in the barriers require permitted only in comparison of the by approved self-classed (See also Section 8 required to have a seguired to have a seguired to have a seguired to have a seguired to have a sessemblies and the including all frame and sills in accordance NFPA 80, Standard Opening Protective specified in this Consideration of the production of th	on, records review, and ity failed to ensure annual ing of at least 1 fire door ompleted in accordance of LSC unicating openings in dividing ad by 19.1.1.4.1 shall be orridors and shall be protected losing fire door assemblies. 3.) LSC 8.3.3.1 Openings fire protection rating by Table tected by approved, listed, asemblies and fire window in accompanying hardware, so, closing devices, anchorage, ance with the requirements of all for Fire Doors and Other ess, except as otherwise ode. NFPA 80 5.2.1 states fire all be inspected and tested not and a written record of the signed and kept for inspection 80, 5.2.4.1 states fire door evisually inspected from both overall condition of door	K 0761	occurring. Any deficiencies wi discussed monthly as part of the Quality Assurance and Performance Improvement (Quality Assurance and Performance Improvement (Quality Assurance and Performance Improvement (Quality Assurance Improvement (Quality Assu	the API) c ill will 03/19/2024 ce ed. ng the es not es anot es

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/05/2024
	PROVIDER OR SUPPLIEI		705 E I	ADDRESS, CITY, STATE, ZIP CO MAIN ST ERVILLE, IN 47330	D
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION (X5) WILD BE COMPLETION PROPRIATE DATE
	assembly. NFPA 8 the following items (1) No open holes of either the door or fit (2) Glazing, vision are intact and secure equipped. (3) The door, frame noncombustible the and in working ord damage. (4) No parts are mit (5) Door clearances listed in 4.8.4 and 6 (6) The self-closing the active door confrom the full open periodical to the confront of the full open periodical to the full open periodica	o), 5.2.4.2 states as a minimum, shall be verified: or breaks exist in surfaces of rame. light frames, and glazing beads ely fastened in place, if so e, hinges, hardware, and eshold are secured, aligned, er with no visible signs of signs or broken. So do not exceed clearances 6.3.1.7. If device is operational; that is, appletely closes when operated position. It is installed, the inactive leaf entire leaf. are operates and secures the		resident hallway was ad TELS for annual inspect Compliance will be mon monthly by the Maintena Director, or designee, for compliance. 4 How the corrective will be monitored to ensideficient practice will notile, what quality assural program will be put into Maintenance Direct designee, will complete inspection as a part of the system. Any deficiencied discussed monthly as part Quality Assurance and Performance Improvement meeting. 5 By what date the sychanges for each deficience of the completed of the complete of the com	ided to tion. itored ance or action(s) ure the t recur, nce place ctor, or the annual ne TELS es will be art of the ent (QAPI) ystemic

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155490	B. WI	NG		03/05/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t .			MAIN ST		
AMBASS	ADOR HEALTHCA	RE		CENTE	RVILLE, IN 47330		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		ew and observation, the					
		or stated the annual fire door					
	inspection was not o	completed within the last year.					
	This finding was ac	knowledged by the					
		Maintenance Director at the					
		nd again at the exit conference.					
	3.1-19(b)						
	3.1-19(0)						
K 0920	NFPA 101						
SS=F		ent - Power Cords and					
Bldg. 01	Extens						
		ent - Power Cords and					
	Extension Cords						
		patient care vicinity are only					
	used for compone						
		ed electrical equipment					
	, ,	les that have been					
		alified personnel and meet 0.2.3.6. Power strips in					
		cinity may not be used for					
		personal electronics),					
	, -	n care resident rooms that					
		E. Power strips for PCREE					
		UL 60601-1. Power strips					
		the patient care rooms					
) meet UL 1363. In					
	`	ooms, power strips meet					
		s. All power strips are					
		precautions. Extension					
	_	d as a substitute for fixed					
		re. Extension cords used					
		moved immediately upon					
		purpose for which it was					
		ts the conditions of 10.2.4.					
		9), 10.2.4 (NFPA 99), 400-8					
	,	(D) (NFPA 70), TIA 12-5					
		on and interview, the facility	K 09	920	1 What corrective action(s)	will	03/19/2024
	failed to ensure 2 of	f 2 flexible cords were not used			be accomplished for those		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155490	B. W	NG		03/05/	2024	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			MAIN ST			
AMDAGG	SADOR HEALTHCA	ABE			ERVILLE, IN 47330			
AIVIDASS	SADOR REALTRO	ARE		CENTE	ERVILLE, IN 47330			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	as a substitute for f	ixed wiring. NFPA-70/2011,			residents found to have been			
	400.8 state unless s	specifically permitted in 400.7			affected by the deficient practi	ce		
	flexible cords and o	cables shall not be used for (1)			The power cord from the	,		
	as a substitute for f	ixed wiring. This deficient			North nurses station was remo	orth nurses station was removed		
	practice could affect	et everyone.			upon discovery during the sur	vey.		
					The 25-amp breaker has beer	1		
	Findings include:				installed the extension cord			
					powering the air compressor h	nas		
	Based on observati	on and interview with the			been removed.			
	Maintenance Direc	tor (MD) and Administrator on			2 How other residents havi	ng		
		12:45p.m. and 3:15 p.m., in (1)			the potential to be affected by	the		
	North Nurses Statio	on an extension cord was			same deficient practice will be	:		
	plugged into a pow	er strip and the extension cord			identified and what corrective			
	was laying across t	he nurse's workstation desk.			action(s) will be taken			
	The MD stated that	the suspected they had done			20 residents and employ	/ees		
	that to charge cell p	phones. Furthermore, (2) in the			had the potential to be affecte	d by		
		ne sprinkler riser, a yellow			the alleged deficient practice a	at		
		powering the air compressor			the nurses station and by the	air		
		facilities dry sprinkler system.			compressor. The air compres	sor		
		the was waiting for a 25-amp			has been wired to a new 25-a	mp		
	_	e outlet and was struggling to			breaker and is operating as			
	locate the breaker.				necessary.			
					3 What measures will be p	ut		
	_	cknowledged by the			into place and what systemic			
		Maintenance Director at the			changes will be made to ensu			
	time of discovery a	and again at the exit conference.			that the deficient practice does	s not		
					recur			
	3.1-19(b)				North unit staff in-service	∌d		
					by March 19, 2024 due to			
					improper extension cords use			
					Weekly tasks will be added to			
					TELS to audit the presence of			
					extension cords at the nurses			
					stations.	, ,		
					4 How the corrective action	` '		
					will be monitored to ensure the			
					deficient practice will not recui	·,		
					i.e., what quality assurance			
					program will be put into place			
I	1		1		Maintenance Director, or	ſ		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 03/05/2024
	PROVIDER OR SUPPLIEF		705 E	ADDRESS, CITY, STATE, ZIP COD MAIN ST ERVILLE, IN 47330	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Gas Equipment - Transfilling of oxy another is in acco Transfilling of Higl Oxygen Used for any gas from one	Transfilling Cylinders Transfilling Cylinders gen from one cylinder to rdance with CGA P-2.5, n Pressure Gaseous Respiration. Transfilling of cylinder to another is nt care rooms. Transfilling		designee, will complete the weekly inspection as a part of the TELS system. Any deficiencie will be discussed monthly as profit of the Quality Assurance and Performance Improvement (Quality Assurance and Performan	s art API)
	to liquid oxygen of containers over 50 under 11.5.2.3.1 (liquid oxygen containers under conditions under 11.5.2.2 (NFPA 98 Based on observation failed to ensure 1 or rooms was provided tanks were full and 11.5.2.3.1(3) states, indicating that trans	ontainers or to portable O psi comply with conditions NFPA 99). Transfilling to cainers or to portable 50 psi comply with 11.5.2.3.2 (NFPA 99).	K 0927	What corrective action(s) be accomplished for those residents found to have been affected by the deficient practic New signage was placed oxygen room by Maintenance Director. This signage reflects	ce in

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155490		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/05/2024	
	PROVIDER OR SUPPLIE		705 E	ADDRESS, CITY, STATE, ZIP COD MAIN ST ERVILLE, IN 47330	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE AP	(X5) COMPLETION DATE
	immediate area is n practice could 20 re	not permitted. This deficient esidents.		locations for full and empty ta fill in progress and no smokin 2 How other residents hav	g.
	Findings include:			the potential to be affected by same deficient practice will be	the
	Maintenance Direc	on and interview with the tor (MD) and Administrator on .2:45p.m. and 3:15 p.m., the		identified and what corrective action(s) will be taken 20 residents have the	
	oxygen storage/trar signage which disti	nsfer room did not contain nguished between full and		potential to be affected by the alleged deficient practice. Ne	ew
	empty storage tank	s. eknowledged by the		signage was placed in oxyger room by Maintenance Director This signage reflects the loca	r.
	Administrator and	Maintenance Director at the nd again at the exit conference.		for full and empty tanks, fill in progress and no smoking.	
	3.1-19(b)			3 What measures will be p into place and what systemic changes will be made to ensu	
				that the deficient practice doe recur	s not
				Maintenance Director, of designee, will observe and verall appropriate signage is in the	rify
				proper locations in the oxyger storage area.	1
				4 How the corrective actio will be monitored to ensure the deficient practice will not recu	e
				i.e., what quality assurance program will be put into place	
				Maintenance Director, of designee, will complete the weekly inspection of signage	
				part of the TELS system. Any deficiencies will be discussed	′
				monthly as part of the Quality Assurance and Performance Improvement (QAPI) meeting	
				5 By what date the system	ic

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		155490	B. WI	NG		03/05/	/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330			
(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
К 0000	REGULTION	ESC IDENTIFY THE IN ORDER THOSE		me	be completed 03/19/2024 Enclosures: Picture – K927 – Signag	e	BAIL
Bldg. 02	Licensure Survey w Department of Heal 483.90(a). Survey Date: 03/05 Facility Number: 0 Provider Number: 1002 At this Life Safety O Healthcare was four Requirements for Po Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (L) Care Occupancies a This two-story facil consists of four atta a one-story building through 120 and Ro two-story section of partial basement. B building consisting Building 03 consists and is a one-story b basement. Building consisting of Room	288750 Code survey, Ambassador and not in compliance with articipation in 42 CFR Subpart 483.90(a), are and the 2012 edition of the cition Association (NFPA) 101, SC) Chapter 19, Existing Health	K 0	000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in generor this corrective action in particular, does not constitute admission or agreement by the facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepare and/or executed in compliance with state and federal laws. The provider respectfully requests this 2567 Plan of Correction be considered the Letter of Creditallegation of Compliance and requests a desk review in lieu post survey review on or after March 14, 2024.	ral, an d e nis that e ble of a	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	
		155490	B. Wl	NG		03/05/	/2024
NAME OF P	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					MAIN ST		
AMBASS	ADOR HEALTHCA	RE		CENTE	RVILLE, IN 47330		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		to be of Type V (111) as surveyed as one building.					
		re alarm system with smoke					
	-	ridor, in spaces open to the					
		evels except the partial					
	basement in the west wing of Building 01. The						
	facility has battery operated smoke detectors in all						
	resident sleeping roo	oms. The facility has a					
	capacity of 137 and had a census of 93 at the time						
	of this visit.						
		1 1					
	All areas where residents have customary access were sprinkled and all areas providing facility						
	services were sprinkled except for the the Soiled						
	•	ette in the West Building.					
	othity and Kitchen	the in the west building.					
	Quality Review con	npleted on 03/06/24					
K 0351	NFPA 101						
SS=E	Sprinkler System -	· Installation					
Bldg. 02	Spinkler System -	Installation					
	2012 EXISTING						
	-	nd hospitals where required					
	by construction type						
		approved automatic					
	•	accordance with NFPA					
		ne Installation of Sprinkler					
	Systems.	nstruction, alternative					
	• •	es are permitted to be					
	•	inkler protection in specific					
	•	or local regulations prohibit					
	sprinklers.						
	-	ders are not required in					
		patient sleeping rooms					
	where the area of	the closet does not exceed					
	6 square feet and	sprinkler coverage covers					
	•	t as required by NFPA 13,					
	Standard for Insta	llation of Sprinkler					
	Systems.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155490		A. BUI	A. BUILDING <u>02</u>			(3) DATE SURVEY COMPLETED 03/05/2024	
	PROVIDER OR SUPPLIER			705 E N	ADDRESS, CITY, STATE, ZIP COD MAIN ST ERVILLE, IN 47330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	19.3.5.1, 19.3.5.2, 19.3.5.5, 19.4.2, 1 Based on observation failed to maintain the accordance with NF Installation of Spring edition, Section 6.2 or other devices use around a sprinkler solution of the section of th	n, 19.3.5.3, 19.3.5.4, 19.3.5.10, 9.7, 9.7.1.1(1) In and interview, the facility the ceiling construction in IPA 13, Standard for the lakler Systems. NFPA 13, 2010 In and interview, the facility the ceiling construction in IPA 13, Standard for the lakler Systems. NFPA 13, 2010 In and interview in the standard space In and interview in the standard space In and interview with the In and interview in the IPA 13, Standard for the IPA 13, Stan	K 03		1 What corrective action(s) be accomplished for those residents found to have been affected by the deficient pract Sprinkler pendants were installed by the contracted ver 2 How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken 13 residents and employ have the potential to be affect by the alleged deficient practic Employees have access to be the soiled utility and kitchenet areas to monitor for the prese of smoke and/or fire. Fire extinguishers are posted in be rooms for use in case of emergency. Custom sprinkler pendants were installed 03/19/2024. 3 What measures will be pinto place and what systemic changes will be made to ensure that the deficient practice doe recur TELS tasks for sprinkler inspections are entered quarter to be completed by contracted company. 4 How the corrective action will be monitored to ensure the deficient practice will not recuive, what quality assurance program will be put into place	ice endor. ing the endor endor ing the endor	03/19/2024
I	I				Maintenance Director of	r	1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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JEFAK I MIEN I	I OF HEALTH AND HUI	VIAN SERVICES	FORM AFFRO			KWI AFFROVED		
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	A. BU	A. BUILDING <u>02</u>			(3) DATE SURVEY COMPLETED 03/05/2024	
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE	
					designee, will verify the presen of all sprinkler pendants. Sprin system is inspected quarterly b	ıkler		

		Quality Assurance and Performance Improvement (QAPI) meeting. 5 By what date the systemic changes for each deficiency will be completed 03/19/2024	
K 0363	NFPA 101		
SS=E	Corridor - Doors		
Bldg. 02	Corridor - Doors		
	Doors protecting corridor openings in other		
	than required enclosures of vertical openings,		
	exits, or hazardous areas resist the passage		
	of smoke and are made of 1 3/4 inch		
	solid-bonded core wood or other material		
	capable of resisting fire for at least 20		
	minutes. Doors in fully sprinklered smoke		
	compartments are only required to resist the		
	passage of smoke. Corridor doors and doors		
	to rooms containing flammable or		
	combustible materials have positive latching		
	hardware. Roller latches are prohibited by		
	CMS regulation. These requirements do not		
	apply to auxiliary spaces that do not contain flammable or combustible material.		
	Clearance between bottom of door and floor		
	covering is not exceeding 1 inch. Powered		
	doors complying with 7.2.1.9 are permissible		
	if provided with a device capable of keeping		
	the door closed when a force of 5 lbf is		
	applied. There is no impediment to the		
	applica. There is no imposition to the		1

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closing of the doors. Hold open devices that release when the door is pushed or pulled are

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contracted vendor to ensure proper operation. Any deficiencies will be discussed monthly as part of the

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	02	COMPLETED	
		155490	B. WI	NG		03/05/	/2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	unlimited height a meeting 19.3.6.3.4 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri resistance of glas assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratio devices, etc. Based on observation failed to ensure 1 or impediment to closs frame and would restrained to ensure 1 or impediment to closs frame and would restrained to ensure 1 or impediment to closs frame and would restrained to ensure 1 or impediment to closs frame and would restrained to ensure 1 or impediment to closs frame and would restrain and would restrain and would restrain and the decent of the control of the contr	If fire window assemblies are a sprinklered compartments of tions in area or fire is or frames in window. Parts 403, 418, 460, 482, 483 and a sings, automatics closing on and interview, the facility of over 30 corridor doors had not ing and latching into the door exist the passage of smoke. In increase, it is a single for an and interview with the tor (MD) and Administrator on 2:45p.m. and 3:15 p.m., the foom failed to close and latch door frame. The door knob was for had a hole of approximately the knob would normally be. at the time of the faintenance Director agreed corridor door did not close foor frame and would not resist kee.	K 03	363	1 What corrective action(s be accomplished for those residents found to have been affected by the deficient pract. The door in question was placed due to the influx of PP received during the declared pandemic. This space is no longer used as a storage over for PPE and does not require door. The door was removed 2 How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken 3 employees have the potential to be affected by the alleged deficient practice. The door was removed as it was relonger necessary. 3 What measures will be point or place and what systemic	rflow a l. ing the	03/19/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED	
		155490	B. WING		03/05/2024	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R				
AMBASS	SADOR HEALTHCA	ARE	705 E MAIN ST CENTERVILLE, IN 47330			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
	Administrator and	Maintenance Director at the		changes will be made to ensu	re	
	time of discovery a	and again at the exit conference.		that the deficient practice does	s not	
				recur		
	3.1-19(b)			Maintenance Director		
				performed inspection on all do	oors	
				in building to verify that doors	to	
				resident's rooms, offices and		
				conference room latch fully int	to	
				door frames with no issues no	oted.	
				Maintenance Director, or		
				designee, will observe and ve	rify	
				all doors latch fully into door		
				frames.		
				4 How the corrective action	n(s)	
				will be monitored to ensure the	e	
				deficient practice will not recu	r,	
				i.e., what quality assurance		
				program will be put into place		
				The Maintenance Direct	or,	
				or designee, will present these		
				audits to the Quality Assurance		
				and Performance Improvemen		
				(QAPI) Committee during mor	•	
				meetings to ensure completion	n	
				and compliance		
				5 By what date the system		
				changes for each deficiency w	vill	
				be completed		
				03/19/2024		
				Enclosures:		
				Picture – K363 – Door		
				Removal		

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