STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155490	A. BUILDING -- B. WING	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMBASSADOR HEALTHCARE	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/05/24 Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750 At this Emergency Preparedness survey, Ambassador Healthcare was found in substantial 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	E 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an 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 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. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155490	A. BUILDING -- B. WING	03/05/2024

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AMBASSADOR HEALTHCARE	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency	E 0004	1 What corrective action(s) will be accomplished for those	03/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 03/05/24 between 10:00 a.m. and 12:45 p.m., the EEP cover page did not have an annual update which was current. The last update to the EPP indicated on the cover page was 01/11/23 and no other date could be found to show the EPP was reviewed and updated within the last year. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference.		residents found to have been affected by the deficient practice Emergency Preparedness Plan was reviewed on March 19, 2024 and follow up on March 28, 2024 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. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur EPP will be scheduled to be reviewed each year as a part of QAPI. Current EPP has been reviewed and updated on March 19, 2024 and follow up will be completed on March 28, 2024. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place QAPI committee will review EPP on an annual basis and as needed. 5 By what date the systemic changes for each deficiency will be completed March 19, 2024 **Enclosures:** **PDF – E004 - Signature Sheet**	

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	155490	A. BUILDING -- B. WING	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must			

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	develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include:	E 0013	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Emergency Preparedness Plan is scheduled has been reviewed on March 19, 2024 and follow up will be on March 28,	03/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Based on records review and interview with the Administrator and the Maintenance Director on 03/05/24 between 10:00 a.m. and 12:45 p.m., the EEP cover page did not have an annual update which was current. The last update to the EPP indicated on the cover page was 01/11/23 and no other date could be found to show EPP Policies and Procedures was reviewed and updated within the last year. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference.		2024 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. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur EPP will be scheduled to be reviewed each year as a part of QAPI. Current EPP has been reviewed and updated on March 19, 2024 and follow up completed will be on March 28, 2024. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place QAPI committee will review EPP on an annual basis and as needed. 5 By what date the systemic changes for each deficiency will be completed March 19, 2024 **Enclosures:** **PDF – E013 Signature Sheet**	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c),			

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	491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 03/05/24 between 10:00 a.m. and 12:45 p.m., the EEP cover page did not have an annual update which was current. The last update to the EPP indicated on the cover page was 01/11/23 and no other date could be found to show EPP's Communication Plan was reviewed and updated within the last year. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference.	E 0029	1 What corrective action(s) will 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 on March 19, 2024 and follow up will be on March 28, 2024 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. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur EPP will be scheduled to be reviewed each year as a part of	03/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			QAPI. Current EPP has been reviewed and updated on March 19, 2024 and follow up will be completed on March 28, 2024. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place QAPI committee will review EPP on an annual basis and as needed. 5 By what date the systemic changes for each deficiency will be completed March 19, 2024 **Enclosures:** **PDF – E029 Signature Sheet**	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d)			

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	Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).			

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	*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed reviewed and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 03/05/24 between 10:00 a.m. and 12:45 p.m., the EEP cover page did not have an annual update which was current. The last update to the EPP indicated on the cover page was 01/11/23 and no other date could be found to show the EPP's Training and Testing Plan was reviewed and updated within the last year. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference.	E 0036	1 What corrective action(s) will 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 reviewed on March 19, 2024 and follow up will be on March 28, 2024 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. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur EPP will be scheduled to be reviewed each year as a part of QAPI. Current EPP has been reviewed and updated on March 19, 2024 and follow up will be	03/19/2024

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			completed on March 28, 2024. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place QAPI committee will review EPP on an annual basis and as needed. 5 By what date the systemic changes for each deficiency will be completed March 19, 2024 **Enclosures:** **PDF – E036 Signature Sheet**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/05/24 Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750 At this Life Safety Code survey, Ambassador Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an 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 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.	

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	This two-story facility with a partial basement consists of four attached buildings. Building 01 is a one-story building consisting of Rooms 101 through 120 and Rooms 1 through 8 in the two-story section of the west wing which has a partial basement. Building 02 is a one-story building consisting of rooms RH1 through RH18. Building 03 consists of Rooms 121 through 135 and is a one-story building with a partial basement. Building IV is a one-story building consisting of Rooms 201 through 220 and Rooms 302 through 313. Each building is fully sprinklered and was determined to be of Type V (111) construction and was surveyed as one building. The facility has a fire alarm system with smoke detection in the corridor, in spaces open to the corridor and on all levels except the partial basement in the west wing of Building 01. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 93 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for the the Soiled Utility and Kitchenette in the West Building . Quality Review completed on 03/06/24			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.			

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AMBASSADOR HEALTHCARE	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of over 10 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 5 residents, staff and visitors if needing to exit the dialysis area. Findings include: Based on observation and interview with the Maintenance Director (MD) and Administrator on 03/05/24 between 12:45p.m. and 3:15 p.m., the exit to the outside in the dialysis unit, marked a facility exit, was obstructed inside the door with carts and equipment containing computers. The MD stated that staff had likely moved the equipment near the exit door because the dialysis unit was very full and busy and there isn't a lot of room to move around. Each of the two paths of egress was marked as a facility exit with an exit sign. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference. 3.1-19(b)	K 0211	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Door leading to the outside sitting area is no longer marked as an “exit” door and signage has been removed. The desk was removed from the dialysis den as well. 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 that utilize the dialysis den have the potential to be affected by the alleged deficient practice. A walk through of the facility was completed to ensure no other exits were affected. No further issues were found. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance to observe exit egress to ensure there are no impediments. 4 How the corrective action(s) 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 ensure that means of egress will be continuously maintained free of impediments	03/11/2024

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	155490	A. BUILDING 01 B. WING	03/05/2024

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			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 systemic changes for each deficiency will be completed. 03/11/2024 Enclosures: PDF - Floor Plan - East Fire Exits PDF - Floor Plan - East Fire Exits (2) Picture - K211 – Desk Sign	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments 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 be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1			

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	through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure 1 of 1 Ansul (pull stations) were not obstructed. NFPA 96, Section 10.5.1 states a readily accessible means for manual activation shall be accessible in the event of a fire.This deficient practice could affect 4 staff in the kitchen. Findings include: Based on observation and interview with the Maintenance Director and Administrator on 03/05/24 between 12:45p.m. and 3:15 p.m., the pull station for the hood Ansul system in the kitchen had a large trash receptacle parked in front of the pull station obstructing access. Based on interview at the times of observation, the Maintenance Director agreed the cart was blocking the pull station. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference. 3.1-19(b)	K 0324	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice The large trash receptacle that was parked in front of the pull station for the Ansul system was removed from the area. All trash receptacles are to have wheels underneath to easily move when necessary. 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 kitchen staff have the potential to be affected by the alleged deficient practice. A walkthrough of the kitchen was completed to ensure no other impediments were in place. No further issues were found. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Dietary staff educated that there are to be no items placed in front of Ansul pull stations. Observations to be completed to ensure there are no Ansul pull station impediments. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.	03/11/2024

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			Dietary Manager, or designee, will round daily to ensure that Ansul pull station impediments are not occurring. Any deficiencies will be discussed monthly as part of the Quality Assurance and Performance Improvement (QAPI) meeting. 5 By what date the systemic changes for each deficiency will be completed 03/11/20024 Enclosures: Picture – K324 – Ansul Pull Station	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:	K 0345	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Koorsen Fire & Security was contacted to schedule the visual semi-annual fire alarm system inspection. This inspection will be completed on 03/22/2024.	03/22/2024

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	a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 03/05/24 between 10:00 a.m. and 12:45 p.m., no documentation was provided during the survey regarding a visual semi-annual fire alarm system inspection. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference. 3.1-19(b)		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 not recur. Repetitive tasks will be entered into TELS to track semi-annual completion of the visual fire alarm inspection. 4 How the corrective action(s) 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-annual TELS task are completed and reports are received from contracted vendor. Any deficiencies will be discussed monthly as part of the Quality Assurance and Performance Improvement (QAPI) meeting. 5 By what date the systemic changes for each deficiency will be completed 03/22/2024 Enclosures: PDF – 03/22/2024 Koorsen	

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			Fire Alarm Inspection	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation 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) Based on observation and interview, the facility failed to provide automatic extinguishing protection for 1 of 1 rooms servicing the facility. This deficient practice could affect 8 residents and staff. Findings include: Based on observation and interview with the Maintenance Director (MD) and Administrator on 03/05/24 between 12:45p.m. and 3:15 p.m., the 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	K 0351	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Sprinkler pendants were installed by the contracted vendor. 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 13 residents and employees have the potential to be affected by the alleged deficient practice.	03/19/2024

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	dry pendent sprinklers and were removed. The facility was waiting on the vendor to custom make replacements for the two dry pendent sprinklers for the aforementioned rooms and no temporary sprinklers were in place. Based on interview at the time of observation, the MD acknowledged the aforementioned rooms were not provided with automatic extinguishing protection. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference. 3.1-19(b)		Employees have access to both the soiled utility and kitchenette areas to monitor for the presence of smoke and/or fire. Fire extinguishers are posted in both rooms for use in case of emergency. Custom sprinkler pendants were installed 03/19/2024. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur TELS tasks for sprinkler inspections are entered quarterly to be completed by contracted company. 4 How the corrective action(s) 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 the presence of all sprinkler pendants. Sprinkler system is inspected quarterly by contracted vendor to ensure proper operation. Any deficiencies will be discussed monthly as part of the Quality Assurance and Performance Improvement (QAPI) meeting. 5 By what date the systemic changes for each deficiency will be completed 03/19/2024	
K 0353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 01	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 Based on observation and interview, the facility failed to maintain the ceiling construction of one storage room. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects 5 residents. Findings include: Based on observation and interview with the Maintenance Director (MD) and Administrator on 03/05/24 between 12:45p.m. and 3:15 p.m., Multiple ceiling tiles were missing in the Dialysis storage room. This finding was acknowledged by the Administrator and Maintenance Director at the	K 0353	1 What corrective action(s) will 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 having the potential to be affected by the 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 are in place currently. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur	03/19/2024

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	time of discovery and again at the exit conference. 3.1-19(b)		A weekly TELS task to ensure all ceiling tiles are in place in storage areas was added 4 How the corrective action(s) 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, to complete TELS task weekly to ensure proper placement of ceiling tiles in storage areas. Any deficiencies will be discussed monthly as part of the Quality Assurance and Performance Improvement (QAPI) meeting. 5 By what date the systemic 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)	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of over 10 portable fire extinguishers were not obstructed in accordance	K 0355	1 What corrective action(s) will be accomplished for those residents found to have been	03/19/2024

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	with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.3 states Fire extinguishers shall be conspicuously located where they are readily accessible and immediately available in the event of fire. This deficient practice could affect 4 staff in the kitchen area. Findings include: Based on observation and interview with the Maintenance Director and Administrator on 03/05/24 between 12:45p.m. and 3:15 p.m., the K-Class fire extinguisher located in the kitchen was blocked by a large trash receptacle. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference. 3.1-19(b)		affected by the deficient practice The large trash receptacle that was parked in front of the K-Class fire extinguisher was removed from the area. All trash receptacles are to have wheels underneath to easily move when necessary. 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 kitchen staff have the potential to be affected by the alleged deficient practice. A walkthrough of the kitchen was completed to ensure no other impediments were in place. No further issues were found. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Dietary staff educated that there are to be no items placed in front of K-Class fire extinguishers. Observations to be completed to ensure there are no K-Class fire extinguishers impediments. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, 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 not	

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			occurring. Any deficiencies will be discussed monthly as part of the Quality Assurance and Performance Improvement (QAPI) meeting. 5 By what date the systemic changes for each deficiency will be completed 03/19/2024 Enclosures: Picture – K355 – K-Class Extinguisher	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door	K 0761	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice The fire door in question was inspected and documented. 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 20 residents have the potential to be affected by the alleged deficient practice. The door has been inspected and inspection has been appropriately documented. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Fire doors separating the Oxygen Transfilling room and the	03/19/2024

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	assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 20 residents. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 03/05/24 between 10:00 a.m. and 12:45 p.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour the Oxygen Transfilling room has one fire door assembly. Based on interview at the		resident hallway was added to TELS for annual inspection. Compliance will be monitored monthly by the Maintenance Director, or designee, for compliance. 4 How the corrective action(s) 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 complete the annual inspection as a 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 systemic changes for each deficiency will be completed 03/19/2024	

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	time of records review and observation, the Maintenance Director stated the annual fire door inspection was not completed within the last year. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference. 3.1-19(b)			
K 0920 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens 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 (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 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used	K 0920	1 What corrective action(s) will be accomplished for those	03/19/2024

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	155490	A. BUILDING 01 B. WING	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect everyone. Findings include: Based on observation and interview with the Maintenance Director (MD) and Administrator on 03/05/24 between 12:45p.m. and 3:15 p.m., in (1) North Nurses Station an extension cord was plugged into a power strip and the extension cord was laying across the nurse's workstation desk. The MD stated that he suspected they had done that to charge cell phones. Furthermore, (2) in the basement next to the sprinkler riser, a yellow extension cord was powering the air compressor associated with the facilities dry sprinkler system. The MD stated that he was waiting for a 25-amp breaker to repair the outlet and was struggling to locate the breaker. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference. 3.1-19(b)		residents found to have been affected by the deficient practice The power cord from the North nurses station was removed upon discovery during the survey. The 25-amp breaker has been installed the extension cord powering the air compressor has been removed. 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 20 residents and employees had the potential to be affected by the alleged deficient practice at the nurses station and by the air compressor. The air compressor has been wired to a new 25-amp breaker and is operating as necessary. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur North unit staff in-serviced 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(s) 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	

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			designee, will complete the weekly inspection as a 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 systemic changes for each deficiency will be completed 03/19/2024 Enclosures: Picture – K920 – Compressor (Closed) Picture – K920 – Compressor (Open)	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer rooms was provided with a sign indicating which tanks were full and which were empty. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring, which tanks are full and empty and that smoking in the	K 0927	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice New signage was placed in oxygen room by Maintenance Director. This signage reflects the	03/19/2024

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	immediate area is not permitted. This deficient practice could 20 residents. Findings include: Based on observation and interview with the Maintenance Director (MD) and Administrator on 03/05/24 between 12:45p.m. and 3:15 p.m., the oxygen storage/transfer room did not contain signage which distinguished between full and empty storage tanks. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference. 3.1-19(b)		locations for full and empty tanks, fill in progress and no smoking. 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 20 residents have the potential to be affected by the alleged deficient practice. New signage was placed in oxygen room by Maintenance Director. This signage reflects the locations for full and empty tanks, fill in progress and no smoking. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Maintenance Director, or designee, will observe and verify all appropriate signage is in the proper locations in the oxygen storage area. 4 How the corrective action(s) 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 complete the weekly inspection of signage as a 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 systemic changes for each deficiency will	

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			be completed 03/19/2024 Enclosures: Picture – K927 – Signage	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/05/24 Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750 At this Life Safety Code survey, Ambassador Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two-story facility with a partial basement consists of four attached buildings. Building 01 is a one-story building consisting of Rooms 101 through 120 and Rooms 1 through 8 in the two-story section of the west wing which has a partial basement. Building 02 is a one-story building consisting of rooms RH1 through RH18. Building 03 consists of Rooms 121 through 135 and is a one-story building with a partial basement. Building IV is a one-story building consisting of Rooms 201 through 220 and Rooms 302 through 313. Each building is fully sprinklered	K 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an 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 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.	

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	and was determined to be of Type V (111) construction and was surveyed as one building. The facility has a fire alarm system with smoke detection in the corridor, in spaces open to the corridor and on all levels except the partial basement in the west wing of Building 01. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 93 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for the the Soiled Utility and Kitchenette in the West Building . Quality Review completed on 03/06/24			
K 0351 SS=E Bldg. 02	NFPA 101 Sprinkler System - Installation 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.			

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	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) Based on observation and interview, the facility failed to maintain the ceiling construction in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states 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. This deficient practice could affect staff and up to 15 residents and staff. Findings include: Based on observation and interview with the Maintenance Director (MD) and Administrator on 03/05/24 between 12:45p.m. and 3:15 p.m., 1 of 1 Sprinkler Head in RH11 was missing the escutcheon and did not completely cover the hole around the sprinkler. This finding was acknowledged by the Administrator and Maintenance Director at the time of discovery and again at the exit conference. 3.1-19(b)	K 0351	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Sprinkler pendants were installed by the contracted vendor. 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 13 residents and employees have the potential to be affected by the alleged deficient practice. Employees have access to both the soiled utility and kitchenette areas to monitor for the presence of smoke and/or fire. Fire extinguishers are posted in both rooms for use in case of emergency. Custom sprinkler pendants were installed 03/19/2024. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur TELS tasks for sprinkler inspections are entered quarterly to be completed by contracted company. 4 How the corrective action(s) 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	03/19/2024

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			designee, will verify the presence of all sprinkler pendants. Sprinkler system is inspected quarterly by contracted vendor to ensure proper operation. Any deficiencies will be discussed monthly as part of the 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 SS=E Bldg. 02	NFPA 101 Corridor - Doors 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 closing of the doors. Hold open devices that release when the door is pushed or pulled are			

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	permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff. Findings include: Based on observation and interview with the Maintenance Director (MD) and Administrator on 03/05/24 between 12:45p.m. and 3:15 p.m., the classroom storage room failed to close and latch positively into the door frame. The door knob was missing and the door had a hole of approximately 3-4 inches where the knob would normally be. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. This finding was acknowledged by the	K 0363	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice The door in question was placed due to the influx of PPE received during the declared pandemic. This space is no longer used as a storage overflow for PPE and does not require a door. The door was removed. 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 3 employees have the potential to be affected by the alleged deficient practice. The door was removed as it was no longer necessary. 3 What measures will be put into place and what systemic	03/19/2024

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	Administrator and Maintenance Director at the time of discovery and again at the exit conference. 3.1-19(b)		changes will be made to ensure that the deficient practice does not recur Maintenance Director performed inspection on all doors in building to verify that doors to resident's rooms, offices and conference room latch fully into door frames with no issues noted. Maintenance Director, or designee, will observe and verify all doors latch fully into door frames. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The Maintenance Director, or designee, will present these audits to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings to ensure completion and compliance 5 By what date the systemic changes for each deficiency will be completed 03/19/2024 **Enclosures:** **Picture – K363 – Door Removal**	