| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G 01, 02 | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--------------------------|--|--------------------|-------------------------------|--|
| | | 155490 | B. WING | B. WING | | R 04/24/2024 | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CO | | | |
| AMBASSADOR HEALTHCARE | | | | 705 E MAIN ST | | | |
| | BORMEALMOARE | | | CENTERVILLE, IN 47330 | FERVILLE, IN 47330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE | (X5) COMPLETIO DATE | |
| {E 000} | Initial Comments | | {E 00 | 0} | | | |
| | A Post Survey revisit (PSR) to the Emergency Preparedness Survey concucted on 03/05/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. | | | | | | |
| | Survey Date: 04/24 | | | | | | |
| | Facility Number: 00 Provider Number: AIM Number: 1002 | 155490 | | | | | |
| | Ambassador Health with Emergency Pro | ency Preparedness survey, ncare was found in compliance eparedness Requirements for caid Participating Providers CFR 483.73. | | | | | |
| | The facility has 137 the survey, the cen | ' certified beds. At the time of sus was 93. | | | | | |
| {K 000} | Quality Review con | - | {K 00 | 0} | | | |
| | Code Recertificatio conducted on 03/05 | sit (PSR) to the Life Safety n and State Licensure Survey 5/24 was conducted by the t of Health in accordance with | | | | | |
| | Survey Date: 04/24 | 4/24 | | | | | |
| | Facility Number: 00 Provider Number: AIM Number: 1002 | 155490 | | | | | |
| | At this PSR Life Sa Ambassador Health | fety Code survey, ncare was found in compliance | | | | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 0 FORMA OMB NO: 0 | PPROVED | | |
|---|---|---|--------------------------|---|----------------------------------|-------------------------------|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION IG 01, 02 | | (X3) DATE SURVEY COMPLETED | | |
| | | 155490 | B. WING | B. WING | | 2024 | | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP | • | | | |
| AMBASSA | DOR HEALTHCARE | | | 705 E MAIN ST | | | | |
| | | | | CENTERVILLE, IN 47330 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI | CTION SHOULD BE C | (X5) OMPLETION DATE | | |
| {K 000} | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 0001 Continued From page 1 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 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. | | {K 00 | 200} | | | | |
| [| | (PSR) to the Life Safety | | | | | | |
| | 7(02-99) Previous Versions Obs | | | Facility ID: 000456 | If continuation sheet | | | |

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

Event ID: CFO222

Facility ID: 000456

If continuation sheet Page 2 of 4

PRINTED: 04/25/2024

| DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | | PRINTED: 04/25/2024 FORM APPROVED OMB NO. 0938-0391 | | |
|---|---|--|--------------------|---|---|----|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02 | | | (X3) DATE SURVEY COMPLETED | | |
| | | 155490 | B. WING | | | | R / 24/2024 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STR | REET ADDRESS, CITY, STATE, ZIP CODE | • | | | |
| AMBASSA | AMBASSADOR HEALTHCARE | | | | E MAIN ST NTERVILLE, IN 47330 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE | | |
| {K 000} | conducted on 03/05/2 Indiana Department of 42 CFR 483.90(a). Survey Date: 04/24/2 Facility Number: 000 Provider Number: 15 AIM Number: 10028 At this PSR Life Safe Ambassador Healthc with Requirements fo Medicare/Medicaid, 4 Life Safety from Fire National Fire Protecti Life Safety Code (LS) Health Care Occupar This two-story facility consists of four attack a one-story building of through 120 and Roo two-story section of th partial basement. Building of Building 03 consists of and is a one-story building of Building of Rooms 302 through 313. Ea sprinklered and was of (111) construction and building. The facility smoke detection in the to the corridor and on basement in the west | and State Licensure Survey 24 was conducted by the of Health in accordance with 24 456 55490 8750 ty Code survey, are was found in compliance r Participation in 22 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C) Chapter 19, Existing ncies and 410 IAC 16.2. with a partial basement hed buildings. Building 01 is consisting of Rooms 101 ms 1 through 8 in the he west wing which has a illding 02 is a one-story rooms RH1 through RH18. of Rooms 121 through 135 ilding with a partial V is a one-story building 201 through 220 and Rooms | {К 0 | 00} | | | | | |

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

Facility ID: 000456

If continuation sheet Page 3 of 4

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | FORM | : 04/25/2024 APPROVED . 0938-0391 | |
|---|--|--|---|---|-------------------------------|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02 | | (X3) DATE SURVEY COMPLETED | | |
| 155490 | | | B. WING | | | R 04/24/2024 | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 0 | | |
| AMBASSADOR HEALTHCARE | | | 705 E MAIN ST CENTERVILLE, IN 47330 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| {K 000} | all resident sleeping r capacity of 137 and h time of this visit. All areas where reside | rooms. The facility has a had a census of 93 at the ents have customary access Il areas providing facility ed. | {K 00 | 0} | | | |

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

If continuation sheet Page 4 of 4