

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330
-----------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/21/11</p> <p>Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Ambassador Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This two story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors excluding the West Hall lounge. The</p>	K0000	Bysubmitting the enclose matyerials we are not admitting the turth or accurancy of any specific findings or allegations as of any proceedings and sub,it these responses pursuant to our regulatory obligations.	

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

TITLE

(X6) DATE

Any defenciency statement ending with an asterisk (*) denotes a defidency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330
-----------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0017 SS=E	<p>facility has a capacity of 137 and had a census of 124 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/23/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 open use area was separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1 Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto</p>	K0017	<p>1. Koorsen was notified of the need for a hard wired smoke detector in the West front lounge.2. To my knowlewgde no resident has been harmed due to the lounge not having a smoke detector.3. Koorsen is to install a hard wired smoke detector in West front Louunge.4. Koorsen to inspect smoke detector on their routine inspections to ensure the safety of the residents. Maintenance will inform the</p>	12/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice affects 16 residents who reside on the West Hall.</p> <p>Findings include:</p> <p>Based on observation on 11/21/11 at 10:44 a.m. with the maintenance supervisor, the West Hall lounge across from the West Hall activity room was open to the corridors. Furthermore, Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. This was verified by the maintenance supervisor at the time of</p>		<p>Administrator of any issues in regards to the smoke detectors. Administrator will report to the Q.A. Committee of any issues with the smoke detectors.5. 12/21/2011</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330
-----------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0020 SS=E	<p>observation.</p> <p>3.1-19(b)</p> <p>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 vertical openings was enclosed with construction having at least a one hour fire resistance. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.4 refers to 7.1.3.2.1 for enclosure of exits. LSC 7.1.3.2.1 requires openings in the separation be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-1.2 requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires fire doors to be closed and latched at the time of fire. This deficient practice could affect 16 residents who reside in the West Hall.</p> <p>Findings include:</p> <p>Based on observation on 11/21/11 at 10:35 a.m. with the maintenance supervisor, the West Hall stairway door to</p>	K0020	<p>1. The door frame and door closure were adjusted so door would close properly.2. No resident was harmed due to this door not closing properly, due to the fact this door is in a secure area that residents cannot asses.3. Door frame and closure were adjusted so that the door would close properly.4. Maintenance to check basement monthly with fire extinguisher checks to ensure that the door is closing properly.5. 12/21/2011</p>	12/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0048 SS=F	<p>the basement failed to latch, and failed to self close into the door frame leaving a one inch gap around the door frame. This was verified by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to have 1 of 1 written health care occupancy fire safety plans which incorporated all items listed in NFPA 101, Section 19.7.2.2.</p> <ol style="list-style-type: none"> 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Response to alarms. 4. Isolation of fire. 5. Evacuation of immediate area. 6. Evacuation of smoke compartment. 7. Preparation of floors and building for evacuation. 8. Extinguishment of fire. <p>This deficient practice affects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on record review on 11/21/11 at 9:50 a.m. with the maintenance</p>	K0048	<ol style="list-style-type: none"> 1. A new Fire policy and Procedure was written and put into place. 2. No residents have been affected by the old Policy & Procedure. The new Policy & Procedure clarifies the old policy. 3. New Policy & Procedure was developed to included all 8 points noted in the NFPA 101 guidelines. Staff in-serviced on 12/15/2011. 4. Staff will be provided with yearly fire in-servicing and fire extinguisher training. Training to be done by retired firefighter. New employees will be provided a copy of the Fire Policy and Procedure. Any fires will be reportrd to ISDH and reviewed by the Q.A. Committee. 5. 12/21/2011 	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330
-----------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0064 SS=C	<p>supervisor, the facility's fire safety plan labeled Disaster Plan did not contain procedures for residents being evacuated from the immediate area of a fire, the evacuation of smoke compartments, or the extinguishment of fire. Furthermore, the Disaster Plan did not address the use of the K class fire extinguisher located in the kitchen in relationship to the use of the kitchen overhead extinguishing system. This was verified by the maintenance supervisor at the time of record review.</p> <p>3.1-19(b)</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to inspect 2 of 12 portable fire extinguishers were inspected for 2 of 2 months since the annual inspection. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place,</p>	K0064	<p>The Maintenance Supervisor inspected to 1 fire extinguisher and informed the Maintenance Assistant of placement of fire extinguisher.2. No resident was harmed due to this fire extinguisher being missed on monthly inspections.3. Extinguisher was inspected by the Maintenance Supervisor. Maintenance Assistant was informed of placement of fire extinguisher and the need to be inspected on monthly inspection.4. The Administrator will spot check inspection tags during monthly inspection rounds.5. 12/21.2011</p>	12/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
K0069 SS=E	<p>it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect any residents using the main dining room in the 100 Hall, and 16 residents who reside on the West Hall.</p> <p>Findings include:</p> <p>Based on an observations with the maintenance supervisor during a tour of the West Hall and 100 Hall from 10:00 a.m. to 12:10 p.m. on 11/21/11, the monthly inspection tag on the fire extinguisher located in the West Hall pantry and the 100 Hall kitchen K class extinguisher each lacked documentation of a monthly inspection for the months of September and October of 2011. This was verified by the maintenance supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 kitchens in accordance with NFPA 96. NFPA 96, 9-1.2.3 requires deep fat fryers be installed at least 16 inches from the surface flames of adjacent cooking</p>	K0069	<p>1. Maintenance informed the Administrator that a plate needed to be installed to seperate the deep fryer and gas range.2. No residents or staff have been affected by the deepfryer & gas range not having a plate between them.3. A plate was purchased</p>	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>equipment unless there is a plate constructed of steel or tempered glass at least eight inches high separating the appliances. This deficient practice could affect all residents in the dining room/kitchen area.</p> <p>Findings include:</p> <p>Based on an observation with the maintenance supervisor on 11/21/11 at 11:45 a.m., the deep fat fryer was located one inch from the gas burners on the commercial cooking stove and did not have a protective shield measuring at least eight inches in height between the two appliances. This was verified by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>and installed.4. Dietary to inform maintenance of any issues regarding the plate.5. 12/21/2011</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0143 SS=E	<p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms was provided with mechanical ventilation. This deficient practice affects 40 residents who reside on the 100 Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 11/21/11 at 12:10 p.m., the 100 Hall liquid oxygen storage room, where eight full liquid oxygen containers were stored, had an electric ceiling fan which was not working. Based on an interview with the administrator on 11/21/11 at 1:15 p.m., the nursing staff transfers liquid oxygen from large containers to small portable containers for resident use in this room. The failure of the electric ceiling exhaust</p>	K0143	<p>1. The ceiling fan in the O2 storage room was repaired after Life Safety exited.2. No resident was affected by the fan not working.3. Ceiling fan was repaired after Life Safety exited.4. Maintenance to check monthly to ensure fan is working properly and inform the Administrator if it needs to be replaced.5. 12/21/2011</p>	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0144 SS=F	<p>fan to work in the liquid oxygen room was verified by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate:</p> <p>1. When the emergency or auxiliary power source is operating to supply power to load.</p> <p>2. When the battery charger is malfunctioning.</p> <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall</p>	K0144	<p>1. Maintenance Supervisor informed the Administrator of issue found with the generator. Generator was installed in 2009 and past by Life Safety. Plan was formulated.2. No residents have been affected due to issues found with generator.3. Cummins is to install the annunciator panel at the North Hall Nurses Station and move the manual stop away from the generator. Hills Electric to install the wiring. Repairs are scheduled for 12/20/2011 by Cummins. Maintenance to write run times on generator sheets. Battery operated lights have been purchased and put inside the generator.4. Maintenance to check lights and panel with weekly tests.5. 12/21/2011</p>	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330
-----------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicate:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/21/11 at 11:50 a.m. with the maintenance supervisor, a remote alarm annunciator for the generator was not provided in a location readily observed by operating personnel at a regular work station such as a nurses' station. Furthermore, the only remote alarm annunciator for the generator was located at the generator, located outside the kitchen exit on the east side of the building. This was verified by</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the maintenance supervisor at the time of observation. 3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around the generator set in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires that emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires that the EPS (Emergency Power Supply) equipment location shall be provided with battery-powered emergency lighting. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 11/21/11 at 11:50 a.m., the emergency generator was located outside the facility with a vinyl fence surrounding the enclosure. The outside generator location was not provided with a battery powered emergency light. This was verified by the maintenance supervisor at the time of observation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330
-----------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator was equipped with a remote manual stop located in a remote location. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation on 11/21/11 at 11:50 a.m. with the maintenance supervisor, the remote manual stop switch for the generator was located on the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330
-----------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>generator but not in a remote location. This was verified by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>4. Based on record review and interview, for 52 of 52 weeks the facility failed to exercise the generator to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
K0000	<p>based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the generator Weekly Test Log with the maintenance supervisor on 11/21/11 at 9:30 a.m., the generator ran under load on a weekly basis for the past year but the time duration was not recorded on the Weekly Test Log. This was verified by the maintenance supervisor at the time of record review.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/21/11</p> <p>Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750</p>	K0000	<p>Bysubmitting the enclose matyerials we are not admitting the turth or accurancy of any specific findings or allegations as of any proceedings and sub,it these responses pursuant to our regulatory obligations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code Survey, Ambassador Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The 2008 Rehabilitation Hall was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This 2008 addition to the one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has the capacity for 137 and had a census of 124 at the time of this survey.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0048 SS=F	<p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1</p> <p>Based on record review and interview, the facility failed to have 1 of 1 written health care occupancy fire safety plans which incorporated all items listed in NFPA 101, Section 19.7.2.2.</p> <ol style="list-style-type: none"> 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Response to alarms. 4. Isolation of fire. 5. Evacuation of immediate area. 6. Evacuation of smoke compartment. 7. Preparation of floors and building for evacuation. 8. Extinguishment of fire. <p>This deficient practice affects all 8 residents who reside on the Rehabilitation Hall.</p> <p>Findings include:</p> <p>Based on record review on 11/21/11 at 9:50 a.m. with the maintenance supervisor, the facility's fire safety plan labeled Disaster Plan did not contain procedures for residents being evacuated from the immediate area of a fire, the evacuation of smoke compartments, or the extinguishment of fire. Furthermore, the Disaster Plan did not address the use of the K class fire extinguisher located in the</p>	K0048	<ol style="list-style-type: none"> 1. A new Fire policy and Procedure was written and put into place. 2. No residents have been affected by the old Policy & Procedure. The new Policy & Procedure clarifies the old policy. 3. New Policy & Procedure was developed to included all 8 points noted in the NFPA 101 guidelines. Staff in-serviced on 12/15/2011. 4. Staff will be provided with yearly fire in-servicing and fire extinguisher training. Training to be done by retired firefighter. New employees will be provided a copy of the Fire Policy and Procedure. Any fires will be reportrd to ISDH and reviewed by the Q.A. Committee. 5. 12/21/2011 	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0064 SS=C	<p>kitchen in relationship to the use of the kitchen overhead extinguishing system. This was verified by the maintenance supervisor at the time of record review.</p> <p>3.1-19(b)</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6</p> <p>Based on observation and interview, the facility failed to inspect 1 of 3 portable fire extinguishers in the Rehabilitation Hall were inspected for 2 of 2 months since the annual inspection. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect all 8 residents who reside on the Rehabilitation Hall.</p> <p>Findings include:</p>	K0064	<p>The Maintenance Supervisor inspected to 1 fire extinguisher and informed the Maintenance Assistant of placement of fire extinguisher.2. No resident was harmed due to this fire extinguisher being missed on monthly inspections.3. Extinguisher was inspected by the Maintenance Supervisor. Maintenance Assistant was informed of placement of fire extinguisher and the need to be inspected on monthly inspection.4. The Administrator will spot check inspection tags during monthly inspection rounds.5. 12/21.2011</p>	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330
-----------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0144 SS=F	<p>Based on an observation with the maintenance supervisor on 11/21/11 at 12:40 p.m., the monthly inspection tag on the fire extinguisher located in the Rehabilitation Hall mechanical room lacked documentation of a monthly inspection for the months of September and October of 2011. This was verified by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate:</p>	K0144	<p>1. Maintenance Supervisor informed the Administrator of issue found with the generator. Generator was installed in 2009 and past by Life Safety. Plan was formulated.2. No residents have been affected due to issues found with generator.3. Cummins is to install the annunciator panel at the North Hall Nurses Station and move the manual stop away from the generator. Hills Electric to install the wiring. Repairs are scheduled for 12/20/2011 by Cummins. Maintenance to write run times on generator sheets. Battery operated lights have been purchased and put inside the generator.4. Maintenance to check lights and panel with weekly tests.5. 12/21/2011</p>	12/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>1. When the emergency or auxiliary power source is operating to supply power to load.</p> <p>2. When the battery charger is malfunctioning.</p> <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all 8 residents who reside on the Rehabilitation Hall.</p> <p>Findings include:</p> <p>Based on observation on 11/21/11 at 11:50 a.m. with the maintenance supervisor, a remote alarm annunciator</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>for the generator was not provided in a location readily observed by operating personnel at a regular work station such as a nurses' station. Furthermore, the only remote alarm annunciator for the generator was located at the generator, located outside the kitchen exit on the east side of the building. This was verified by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around the generator set in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires that emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires that the EPS (Emergency Power Supply) equipment location shall be provided with battery-powered emergency lighting. This deficient practice could affect 8 residents who reside on the Rehabilitation Hall.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 11/21/11 at 11:50 a.m.,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330
-----------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the emergency generator was located outside the facility with a vinyl fence surrounding the enclosure. The outside generator location was not provided with a battery powered emergency light. This was verified by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop located in a remote location. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect 8</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>residents who reside on the Rehabilitation Hall.</p> <p>Findings include:</p> <p>Based on observation on 11/21/11 at 11:50 a.m. with the maintenance supervisor, the remote manual stop switch for the generator was located on the generator but not in a remote location. This was verified by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>4. Based on record review and interview, for 52 of 52 weeks the facility failed to exercise the generator to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect 8 residents who reside on the Rehabilitation Hall.</p> <p>Findings include:</p> <p>Based on a review of the generator Weekly Test Log with the maintenance supervisor on 11/21/11 at 9:30 a.m., the generator ran under load on a weekly basis for the past year but the time duration was not recorded on the Weekly Test Log. This was verified by the maintenance supervisor at the time of record review.</p> <p>3.1-19(b)</p>				