

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
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NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN 47330
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K 000 Bldg. 01	<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: 05/14/15</p> <p>Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750</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 with a partial basement was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including the partial basement, the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident</p>	K 000		

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

TITLE

(X6) DATE

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

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K 027 SS=E Bldg. 01	<p>sleeping rooms. The facility has a capacity of 137 and had a census of 128 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the detached storage building and the detached walk in cooler and walk in freezer.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 9 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This</p>	K 027	<p>On 06/01/15 the South 200 hall was repaired with a solid metal strip which completes a clearance of <1/8 inch to restrict the movement of smoke. All residents residing on South 200 are determined to be affected. An in-service was held with the maintenance dept staff on 05/29/15 to discuss the Life Safety citations and corrections. The staff was educated on specific rules cited. A maintenance staff member will be assigned the task of inspecting all</p>	06/13/2015

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K 062 SS=F Bldg. 01	<p>deficient practice could affect 24 residents who reside on the 200 Hall.</p> <p>Findings include:</p> <p>Based on observation on 05/14/15 at 11:45 a.m. with the maintenance supervisor, the 200 Hall set of smoke barrier doors had a one inch gap along the center where the doors came together in the closed position. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 05/14/15 at 2:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure a complete flushing program was conducted after an obstruction investigation was completed on 1 of 1 automatic dry sprinkler piping system which indicated the presence of scale and silt buildup in the sprinkler piping. NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems,</p>	K 062	<p>smoke barrier doors for compliant smoke clearance monthly. This will be documented on the monthly maintenance checklist. This information will be reviewed and monitored by the maintenance supervisor. QA/QI Committee meetings are held quarterly. Life Safety issues are included in the Committee meeting for review and compliance improvement. The maintenance supervisor and administrator will continue monthly review for monitoring. Completion date 06/13/15</p> <p>On 12/12/14 the sprinkler system had been inspected. The facility had planned for flushing and maintenance of the sprinkler system as evidenced by the December evaluation of</p>	06/13/2015

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	<p>10-2.3 requires if an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 05/14/15 at 9:10 a.m., the most recent sprinkler system internal pipe inspection from Koorsen Fire & Security was the cover page of the report dated 12/12/14 and the results of the report were not available for review.</p> <p>Based on a telephone interview with Koorsen Fire & Security on 05/14/15 at 9:30 a.m., the service manager indicated the 12/12/14 internal pipe inspection revealed a buildup of debris in the sprinkler piping and further action was required by the facility. Based on an interview with the maintenance supervisor on 05/14/15 at 9:45 a.m., when asked if the sprinkler system flushing was conducted to remove piping debris as a follow up action to the internal pipe inspection report dated 12/12/14, the maintenance supervisor</p>		<p>the system. The facility had requested bids for the flushing and maintenance of the system. The date for the work had not been determined at the time of the survey.(The evaluation did not reveal an obstruction).Historically the contracted alarm/sprinkler company frequents the building for maintenance and repair. Due to continuous maintenance, the system is in reliable operating condition. Flushing and maintenance of the system is scheduled starting on 7/6/15.On 5/26/15 three hydrants located on the facility property have been flushed and serviced by the Alarm/Sprinkler company.On 5/27/15 the kitchen sprinkler above the dish machine was replaced. Additional</p>	

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	<p>stated the facility did not have the complete sprinkler flushing conducted and were still getting estimates. The lack of recommended follow up action taken after the internal pipe inspection of the sprinkler system was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 05/14/15 at 2:10 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 private fire hydrant was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 05/14/15 at 1:00 p.m. with the maintenance supervisor, the</p>		<p>sprinklers were identified by the maintenance supervisor and repaired with new escutcheons replaced. The facility determines that all residents, staff, or visitors have the potential to be affected. A periodic schedule has been created to include; internal sprinkler inspections and annual hydrant maintenance. This schedule will be reviewed by the maintenance supervisor monthly for intervention. Sprinkler head inspections are on the monthly checklist. A maintenance staff member is assigned to inspect sprinkler heads throughout the facility, for corrosion or replacement an in-service was given to maintenance staff on 5/29/15 to review citations and educate on the monthly check list</p>	

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	<p>facility had one private fire hydrant at the east parking lot. Based on an interview with the maintenance supervisor on 05/14/15 at 1:15 p.m., there is no documentation of an annual inspection for the fire hydrant. The lack of an annual inspection for the one fire hydrant located in the east parking lot was acknowledged by the administrator at the exit conference on 05/14/15 at 2:10 p.m.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to replace 1 of over 300 sprinklers in the facility covered in corrosion. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 68 residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 05/14/15 at 12:30 p.m. with the maintenance</p>		<p>requirements. QA/QI committee meeting is held quarterly. The Maintenance Supervisor and Administrator will review annual and monthly Life Safety needs with the committee, to determine monitoring of timely compliance. Additionally facility maintenance needs are reviewed at each morning meeting. Compliance Date: June 13, 2015</p>	

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K 000 Bldg. 02	<p>supervisor, the kitchen sprinkler above the dish washing machine was completely covered in green corrosion. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 05/14/15 at 2:10 p.m.</p> <p>3.1-19(b)</p> <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: 05/14/15</p> <p>Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750</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.</p>	K 000		

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K 062 SS=F Bldg. 02	<p>The 2008 Rehabilitation Hall was surveyed with Chapter 18, New Health Care Occupancies. This 2008 addition to the one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 128 at the time of this survey.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the detached storage building and the detached walk in cooler and walk in freezer.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure a complete flushing program was conducted after an obstruction investigation was conducted on 1 of 1 automatic dry sprinkler piping system which indicated the presence of scale and silt buildup in the sprinkler piping. NFPA 25, the Standards for the</p>	K 062	On 12/12/14 the sprinkler system had been inspected. The facility had planned for flushing and maintenance of the sprinkler system as	06/13/2015			

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	<p>Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 10-2.3 requires if an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all residents who reside on the Rehabilitation Hall.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 05/14/15 at 9:10 a.m., the most recent sprinkler system internal pipe inspection from Koorsen Fire & Security was the cover page of the report dated 12/12/14 and the results of the report were not available for review.</p> <p>Based on a telephone interview with Koorsen Fire & Security on 05/14/15 at 9:30 a.m., the service manager indicated the 12/12/14 internal pipe inspection revealed a buildup of debris in the sprinkler piping and further action was required by the facility. Based on an interview with the maintenance supervisor on 05/14/15 at 9:45 a.m., when asked if the sprinkler system flushing was conducted to remove piping debris as a follow up action to the</p>		<p>evidenced by the December evaluation of the system. The facility had requested bids for the flushing and maintenance of the system. The date for the work had not been determined at the time of the survey.(The evaluation did not reveal an obstruction).Historically the contracted alarm/sprinkler company frequents the building for maintenance and repair. Due to continuous maintenance, the system is in reliable operating condition. Flushing and maintenance of the system is scheduled starting on 7/6/15.On 5/26/15 three hydrants located on the facility property have been flushed and serviced by the Alarm/Sprinkler company.On 5/27/15 the kitchen sprinkler above</p>	

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	<p>internal pipe inspection report dated 12/12/14, the maintenance supervisor stated the facility did not have the complete sprinkler flushing conducted and were still getting estimates. The lack of recommended follow up action taken after the internal pipe inspection of the sprinkler system was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 05/14/15 at 2:10 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 private fire hydrant was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all residents who reside on the Rehabilitation Hall.</p> <p>Findings include:</p> <p>Based on observation on 05/14/15 at 1:00</p>		<p>the dish machine was replaced. Additional sprinklers were identified by the maintenance supervisor and repaired with new escutcheons replaced. The facility determines that all residents, staff, or visitors have the potential to be affected. A periodic schedule has been created to include; internal sprinkler inspections and annual hydrant maintenance. This schedule will be reviewed by the maintenance supervisor monthly for intervention. Sprinkler head inspections are on the monthly checklist. A maintenance staff member is assigned to inspect sprinkler heads throughout the facility, for corrosion or replacement an in-service was given to maintenance staff on 5/29/15 to review</p>	

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K 038 SS=E Bldg. ID	<p>p.m. with the maintenance supervisor, the facility had one private fire hydrant at the east parking lot. Based on an interview with the maintenance supervisor on 05/14/15 at 1:15 p.m., there is no documentation of an annual inspection for the fire hydrant. The lack of an annual inspection for the one fire hydrant located in the east parking lot was acknowledged by the administrator at the exit conference on 05/14/15 at 2:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the sidewalk surface on 2 of 9 exit sidewalks was maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be</p>	K 038	<p>citations and educate on the monthly check list requirements. QA/QI committee meeting is held quarterly. The Maintenance Supervisor and Administrator will review annual and monthly Life Safety needs with the committee, to determine monitoring of timely compliance. Additionally facility maintenance needs are reviewed at each morning meeting. Compliance Date: June 13, 2015</p> <p>On 5/25/15 the South 200 exit sidewalk was repaired. The deck boards, warped or pitted have been replaced to insure the walking surface does not exceed 1/4 inch. On 5/28/15 the 10 ft. section of the West hall exit ramp has been repaired. The surface has been leveled to insure that the surface does not exceed 1/4 inch. The entire ramp surface will be leveled by the June 13, 2015</p>	06/13/2015

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	<p>considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice could affect 24 residents who reside on the 200 Hall and 14 residents who reside on the West Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 05/14/15 during a tour of the facility from 9:45 a.m. to 2:10 p.m. with the maintenance supervisor, the following sidewalk surfaces had changes in elevation;</p> <p>1. The 200 Hall exit sidewalk had a twenty foot section of wooden decking leading to a paved sidewalk.</p> <p>Furthermore, the wooden deck had two six foot long deck boards warped on the outer edges and loose fitting with nails sticking up from the deck boards.</p> <p>2. The West Hall exit sidewalk had a ten foot by twelve foot section of sidewalk which was pitted and cracking with one inch depressions in the sidewalk surface along the ten foot length of sidewalk.</p> <p>The 200 Hall exit deck boards warped and the West Hall exit sidewalk surface pitting was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 05/14/15 at 2:10 p.m.</p> <p>3.1-19(b)</p>		<p>compliance date. The facility has identified any resident exiting the West hall or South 200 hall as having the potential to be affected. If the residents use these exits, they will be supervised by staff. An in-service was held with the maintenance dept on 5/29/15 to discuss the Life Safety citations and corrections. The staff was educated on specific rules cited. A maintenance staff member will be assigned the task of inspecting all exit surfaces to insure smooth and level surfaces. The results of the inspection will be entered on the monthly maintenance check list and reported to the maintenance supervisor for intervention. During morning meeting all maintenance issues are discussed for timely intervention. This will include general exterior/exit concerns. Quarterly the QA/QI committee meets. Life Safety concerns will be included in the next meeting and continue quarterly for monitoring compliance. Compliance Date: June 13, 2015</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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