

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 04/03/2014
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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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K010000	<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: 04/03/14</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 with a partial basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including in the partial basement, in the</p>	K010000	<p>By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations as of any proceedings and submit these responses pursuant to our regulatory obligations</p> <p>We are requesting a desk review for this survey</p>	
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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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	<p>corridors, in spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 118 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except the detached storage building, the detached walk in cooler and walk in freezer.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/08/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 6 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. This deficient practice could affect 65 residents who reside on the 200 Hall and 300 Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 04/03/14 during observations of the smoke barrier walls above the drop ceiling assembly from 12:40 p.m. to 1:30 p.m., the 200 Hall smoke barrier wall had two, six inch penetrations filled with expandable foam. Furthermore, the 300 Hall smoke barrier wall had a two inch circular penetration from a telephone wire with no fire stopping material. Based on an interview with the maintenance supervisor on 04/03/14 at 1:00 p.m., the expandable</p>	K010025	<p>1 The hole with caulking was cleaned out and fire retardent caulk was put in hole to close it off. The second hole was filled with fire retatdent caulk. 2 No resident was harmed do to these to these 2 holes in the firewall. 3. Maintenance will check all attic firewalls in the Spring and Fall to look for any open areas that need to be caulked with fire retardant caulk due to repairs to the buildings or extreme weather conditions.</p> <p>4. Any areas found will be will be reported at the quarterly Q.A. Meetings. Maintenance Supervisor will immediately report any areas that are found with a completion date of repair.</p> <p>5. 4/4/2014</p>	04/04/2014			

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	<p>foam used to seal the 200 Hall smoke barrier penetrations was not a fire rated material. The unrated expandable foam used as a fire stopping material in the 200 Hall smoke barrier wall and the 300 Hall smoke barrier penetration were acknowledged by the administrator at the exit conference on 04/03/14 at 1:30 p.m.</p> <p>3.1-19(b)</p>			

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K010038 SS=E	<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</p> <p>Based on observation and interview, the facility failed to ensure 2 of 10 exit doors with delayed egress locks were provided with signs indicating PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided:</p> <p>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.</p> <p>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release</p>	K010038	<p>1 The 15 seconds was removed from both doors on the South Unit Both doors have key pads to open doors The is a secure Alzheimer's Unit and placing a sign could endanger our residents 2 No residents have been injured or eloped do to the 15 second device on either door. 3 Staff have been notified on that unit that they will have to use the key pad to exit from both doors. 4 Maintenance will monitor monthly to ensure that keypads are in good working order. Maintenance will notify the Administrator immediately of any issues and when keypads have been fixed. Maintenance will report to the quarterly Q.A. Meeting of any issues during the quarter with keypads. 5. 4/4/2014</p>	04/04/2014			

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	<p>the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 65 residents who reside on the 200 Hall and the 300 Hall.</p> <p>Findings include:</p> <p>Based on observation on 04/03/14 during a tour of the 200 Hall and 300 Hall with the maintenance supervisor from 11:10 a.m. to 12:20 p.m., the 200 Hall exit door and the 300 Hall exit door had a fifteen second delay when force was applied to the releasing device on each door.</p>						

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	<p>Furthermore, the 200 Hall and 300 Hall exit doors each lacked a sign reading, PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 04/03/14 at 1:30 p.m.</p> <p>3.1-19(b)</p>			

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	<p>wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 118 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except the detached storage building, the detached walk in cooler and walk in freezer.</p>			
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