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	06/11/2025

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: 06/11/25 Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750 At this Emergency Preparedness survey, Ambassador Healthcare was found in 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 107. Quality Review completed on 06/16/25	E 0000		
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: 06/11/25 Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750 At this Life Safety Code survey, Ambassador Healthcare was found not in compliance with	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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jared Glaub	Executive Director	06/24/2025

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 01 B. WING	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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	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 107 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 Soiled Utility and Kitchenette in the West Building . Quality Review completed on 06/16/25		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 June 24, 2025.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure			

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	155490	A. BUILDING 01 B. WING	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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	Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 hazardous area, such as a House Keeping/Bio-hazard room or a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 14 residents in the 2500 Hall plus any number of residents, staff and visitors while in the second-floor center area. Findings include: Based on observations made during a tour of the facility with the facility Administrator and the Maintenance Director on 06/11/25 at 1:30 p.m., the Activities room in building #1 had numerous cardboard boxes of miscellaneous items, wooden chairs, and storage that created a hazardous environment. This room measured approximately 150 square feet in size and was being used for building storage. The corridor door to this room was not provided with a self-closing device. Based on an interview with the Maintenance Director on 06/11/25 at 1:33 p.m., he advised that he would address the deficiency as soon as possible. This finding was reviewed with facility Administrator and the Maintenance Director at the exit conference on 06/11/25. 3.1-19(b)	K 0321	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. On June 19, 2025, the facility's maintenance and housekeeping staff assessed the activity room. Excessive combustible materials were removed from the room and relocated to a designated storage area compliant with NFPA 101 requirements. The room was inspected to confirm it no longer contains combustible materials in quantities that classify it as a hazardous area. 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. 14 residents have the potential to be affected by the alleged deficient practice. The facility conducted an audit of rooms over 50 square feet to identify any other areas containing combustible materials that could classify them as hazardous areas. Any rooms found to contain excessive combustible materials were either cleared of such items or reclassified and equipped with appropriate protections. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	06/20/2025

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	155490	A. BUILDING 01 B. WING	06/11/2025

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			recur. The facility implemented a monthly routine inventory control program to monitor the contents of rooms over 50 square feet. 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 conduct weekly inspections of all rooms over 50 square feet for the first three months following correction to verify that combustible materials are stored in non-compliant 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. 06/20/2025	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0345	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice On 06/19/2025, the Maintenance Director contacted the fire alarm service company to schedule a service visit to update the fire alarm control panel to display the correct date and time.	06/20/2025

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	Based on observations made during a tour of the facility with the facility Administrator and the Maintenance Director on 06/11/25 at 1:20 p.m., the fire alarm control panel located in the Building 1 nurses' station displayed an incorrect date and time. The display on the main fire alarm control panel indicated the date and time to be 00/00/00 at 6:39 a.m. Based on interview on 06/11/25 at 1:22 p.m., the Maintenance Director indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed date and time updated on the fire alarm control panel so that it had the correct date and time displayed. This finding was reviewed with facility Administrator and the Maintenance Director at the exit conference on 06/11/25. 3.1-19(b)		The service was completed on 06/20/2025, and the fire alarm control panel now displays the correct date and time, verified by the Maintenance Director. 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. On 06/20/2025, the Maintenance Director conducted a comprehensive inspection of the fire alarm control panel and related systems throughout the facility to ensure no other discrepancies exist. 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. The facility has revised its fire alarm system maintenance protocol to include a monthly check of the fire alarm control panel's date and time accuracy, effective 06/20/2025. 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 document these checks on TELS. Any	

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			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 06/20/2025	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 4 buildings 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 as many as 40 residents, 6 staff and 2 visitors within the building #1 compartment. Findings include: Based on observations made during a tour of the facility with the facility Administrator and the Maintenance Director on 06/11/25 at 1:12 p.m., the sprinkler head located in the building #1 corridor between resident room #109 and #110 had a loose escutcheon showing approximately one-quarter inch of annular space. Based on interview on 06/11/25 at 1:14 p.m., the Maintenance Director acknowledged the annular space and advised that he was checking these daily as they have been replacing ceiling tiles throughout the facility. This finding was reviewed with facility Administrator and the Maintenance Director at	K 0351	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice On 06/24/2025, the Maintenance Director replaced the drop ceiling panel around the sprinkler escutcheon located in the corridor between resident rooms 109 and 110, eliminating the annular space. 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 40 residents and employees have the potential to be affected by the alleged deficient practice. The Maintenance Director conducted an inspection of sprinkler heads in building #1 on 06/24/2025 to ensure no other escutcheons were loose. No additional deficiencies were found. 3 What measures will be put into place and what systemic changes will be made to ensure	06/24/2025

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	the exit conference on 06/11/25. 3.1-19(b)		that the deficient practice does not recur The facility has revised its fire alarm system maintenance protocol to include an ongoing weekly check of escutcheons and appropriate annular space, effective 06/24/2025. 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 conduct weekly inspections of all sprinkler heads throughout the facility to ensure escutcheons are secure and no annular spaces are present. 5 By what date the systemic changes for each deficiency will be completed 06/24/2025	
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: 06/11/25 Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750 At this Life Safety Code survey, Ambassador Healthcare was found not in compliance with	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	

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	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 except for the Soiled Utility and Kitchenette in the West Building. Quality Review completed on 06/16/25		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 June 24, 2025.	
K 0351 SS=E Bldg. 02	NFPA 101 Sprinkler System - Installation			

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	Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 4 buildings 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 as many as 40 residents, 6 staff and 2 visitors within the building #2 compartment. Findings include: Based on observations made during a tour of the facility with the facility Administrator and the Maintenance Director on 06/11/25 at 1:36 p.m., the sprinkler head located in the building #2 resident room #RH 13 had a loose escutcheon showing approximately one-half inch of annular space. Based on interview on 06/11/25 at 1:37 p.m., the Maintenance Director acknowledged the annular space and advised that he was checking these daily as they have been replacing ceiling tiles throughout the facility and that he would address this issue as soon as possible. This finding was reviewed with facility Administrator and the Maintenance Director at the exit conference on 06/11/25. 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 On 06/20/2025, the Maintenance Director replaced the escutcheon located in resident room RH13, eliminating the annular space. 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 40 residents and employees have the potential to be affected by the alleged deficient practice. The Maintenance Director conducted an inspection of sprinkler heads in building #2 on 06/20/2025 to ensure no other escutcheons were loose. No additional deficiencies 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 The facility has revised its fire alarm system maintenance protocol to include an ongoing weekly check of escutcheons and appropriate annular space, effective 06/20/2025. 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,	06/20/2025

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			or designee, will conduct weekly inspections of all sprinkler heads throughout the facility to ensure escutcheons are secure and no annular spaces are present. 5 By what date the systemic changes for each deficiency will be completed 06/20/2025	
K 0000 Bldg. ID	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: 06/11/25 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.	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 June 24, 2025.	

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	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 107 at the time of this visit. Quality Review completed on 06/16/25			
K 0363 SS=E Bldg. ID	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 82 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing or latching, and would resist the passage of smoke by latching into the door frame. This deficient practice could affect 20 residents, 2 staff and 2 visitors in the building #4 compartment. Findings include: Based on observations made during a tour of the facility with the facility Administrator and the Maintenance Director on 06/11/25 at 2:10 p.m., the corridor door to resident room #217 failed to latch into the door frame after multiple attempts. Based on interview on 06/11/25 at 2:12 p.m., the Maintenance Director acknowledged the aforementioned corridor door stating that he	K 0363	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice The Maintenance Director repaired the corridor door to resident room #217 to ensure it latches securely into the door frame. This included inspecting and adjusting the door latch, strike plate, and hinges as needed. 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. All	06/20/2025

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	would attempt to fix the door as soon as possible. This finding was reviewed with facility Administrator and the Maintenance Director at the exit conference on 06/11/25. 3.1-19(b)		resident room corridor doors were verified to latch properly in compliance with K363 requirements. Any additional doors found to be non-compliant were repaired. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur The Maintenance Director will inspect proper door maintenance, including checking for latching mechanisms, alignment, and hardware integrity. Any issues were immediately corrected. 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 monthly to ensure proper latching of corridor doors. 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 06/20/2025	