PRINTED: 06/25/2025 FORM APPROVED

ENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES		OMB NO. 0938-039			
	NT OF DEFICIENCIES OF CORRECTION					(X3) DATE SURVEY COMPLETED 06/11/2025	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
E 0000 Bldg	conducted by the I accordance with 42 Survey Date: 06/1 Facility Number: Provider Number: AIM Number: 100 At this Emergency Ambassador Healt with Emergency P Medicare and Mediand Suppliers, 42 0	1/25 000456 155490 0288750 Preparedness survey, hcare was found in compliance reparedness Requirements for licaid Participating Providers CFR 483.73. 7 certified beds. At the time of	E 0000				
K 0000 Bldg. 01	A Life Safety Cod	000456 155490	K 0000	DISCLAIMER STATEMENT: Preparation and/or execution this plan of correction in gene or this corrective action in particular, does not constitute admission or agreement by th facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepare	ral, an iis		

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

At this Life Safety Code survey, Ambassador

Healthcare was found not in compliance with

TITLE (X6) DATE

and/or executed in compliance

with state and federal laws. This

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1J7X21 Facility ID: 000456 If continuation sheet Page 1 of 12

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

PRINTED: 06/25/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490		UILDING	onstruction 01	(X3) DATE COMPL 06/11 /	ETED
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protect Life Safety Code (I Care Occupancies a This two-story facil consists of four atta a one-story building through 120 and Ro two-story section or partial basement. B building consisting Building 03 consist and is a one-story b basement. Building consisting of Room 302 through 313. E and was determined construction and wa The facility has a fi detection in the cor corridor and on all basement in the we facility has battery resident sleeping ro capacity of 137 and time of this visit. All areas where res were sprinkled and services were sprinkled and services were sprinkled and services were sprinkled and	articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, LSC) Chapter 19, Existing Health			provider respectfully requests this 2567 Plan of Correction b considered the Letter of Credi Allegation of Compliance and requests a desk review in lieu post survey review on or after 24, 2025.	e ble of a	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas	- Enclosure					

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

Event ID: 1J7X21 Facility ID: 000456

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) Da		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED
		155490	B. W	ING		06/11/2025
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIE	R			MAIN ST	
AMBASS	SADOR HEALTHCA	ARE		CENTERVILLE, IN 47330		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		on and interview, the facility	K 0	321	1 What corrective action(s) will 06/20/2025
		corridor door to 1 of 1			be accomplished for those	
	hazardous area, suc				residents found to have been	
		d room or a storage room of			affected by the deficient pract	ice.
		es over 50 square feet in size,			On June 19, 2025, the	
	_	a self-closing device which			facility's maintenance and	
		or to automatically close and			housekeeping staff assessed	the
		frame. This deficient practice			activity room. Excessive	
		dents in the 2500 Hall plus any			combustible materials were	
		s, staff and visitors while in the			removed from the room and	
	second-floor center	area.			relocated to a designated stor	•
	Findings include:				area compliant with NFPA 10	
					requirements. The room was	• • • • • • • • • • • • • • • • • • •
					inspected to confirm it no long	·
	Based on observations made during a tour of the				contains combustible material	ls in
	· ·	cility Administrator and the			quantities that classify it as a	
		tor on 06/11/25 at 1:30 p.m., the			hazardous area.	
		building #1 had numerous			2 How other residents hav	_
		miscellaneous items, wooden			the potential to be affected by	
		that created a hazardous			same deficient practice will be	
		room measured approximately			identified and what corrective	
		size and was being used for			action(s) will be taken.	
		he corridor door to this room			14 residents have the	
		vith a self-closing device.			potential to be affected by the	• • • • • • • • • • • • • • • • • • •
		iew with the Maintenance			alleged deficient practice. Th	e
		25 at 1:33 p.m., he advised that			facility conducted an audit of	
		he deficiency as soon as			rooms over 50 square feet to	in in a
	possible.				identify any other areas conta	- I
	This finding was	vioused with facility			combustible materials that co	uia
	_	eviewed with facility the Maintenance Director at			classify them as hazardous	
	the exit conference				areas. Any rooms found to contain excessive combustible	_
	uie exit conference	OH OO/ 11/23.			materials were either cleared	=
	3.1_10/b)				such items or reclassified and	= -
	3.1-19(b)					'
					equipped with appropriate	
					protections.	t
					3 What measures will be p	uı
					into place and what systemic	uro.
					changes will be made to ensu	
					that the deficient practice doe	S HOL

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

PRINTED: 06/25/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155490	A. BUILDING B. WING	01	COMPLETED 06/11/2025	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				recur. The facility implemented monthly routine inventory cont program to monitor the content rooms over 50 square feet. How the corrective action 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 5 square feet for the first three months following correction to verify that combustible materia are stored in non-compliant areas. Any deficiencies will be discussed monthly as part of the Quality Assurance and Performance Improvement (Quineeting. By what date the systemi changes for each deficiency we be completed. 06/20/2025	rol tts of n(s) e c f f f f f f f f f f f f f f f f f f	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System Maintenance	-	IV 0245	1 What corrective action(a)	oc/20/2025	
	failed to maintain the that it had accurate accordance with the 2012 edition, Section - 2010 edition - 20	on and interview, the facility are fire alarm system to assure time and date information in requirements of NFPA 101-ons 19.3.4 and 9.6 and NFPA 72 ions 14.1, 14.1.1. This deficient t all residents, staff and	K 0345	What corrective action(s) be accomplished for those residents found to have been affected by the deficient practi On 06/19/2025, the Maintenance Director contacte the fire alarm service company schedule a service visit to upd the fire alarm control panel to display the correct date and tir	ce ed y to ate	

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Event ID:

1J7X21

Facility ID: 000456

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SU	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155490	B. WING			06/11/2	025
				CEREE	ADDRESS CHILL STATE THE SOD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
1 445466	A D O D LIE A L TU O A	DE.			MAIN ST		
AMBASS	SADOR HEALTHCA	AKE		CENTE	ERVILLE, IN 47330		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					The service was completed or	n	
	Based on observati	ons made during a tour of the			06/20/2025, and the fire alarm		
		cility Administrator and the			control panel now displays the		
	-	tor on 06/11/25 at 1:20 p.m., the			correct date and time, verified		
		panel located in the Building 1			the Maintenance Director.		
		layed an incorrect date and			2 How other residents havi	na	
		on the main fire alarm control			the potential to be affected by	_	
		date and time to be 00/00/00 at			same deficient practice will be		
	-	interview on 06/11/25 at 1:22			identified and what corrective		
		nce Director indicated he was			action(s) will be taken.		
	* '	crepancy and would contact			All residents have the		
		to have the displayed date and			potential to be affected by the		
		e fire alarm control panel so			alleged deficient practice. On		
	•	ect date and time displayed.			06/20/2025, the Maintenance		
	litat it had the corre	et date and time displayed.			Director conducted a		
	This finding was re	eviewed with facility			comprehensive inspection of t	·he	
		the Maintenance Director at			fire alarm control panel and re		
	the exit conference				systems throughout the facility		
	life out conference	011 00/11/23:			ensure no other discrepancies		
	3.1-19(b)				exist. No further issues were	^	
	0.1 15(0)				found.		
					3 What measures will be p	ut	
					into place and what systemic	u.	
					changes will be made to ensu	re	
					that the deficient practice does		
					recur.		
					The facility has revised i	ts	
					fire alarm system maintenance		
					protocol to include a monthly		
					check of the fire alarm control		
					panel's date and time accurac		
					effective 06/20/2025.	,	
					4 How the corrective action	n(s)	
					will be monitored to ensure the	` '	
					deficient practice will not recu		
					i.e., what quality assurance	,	
					program will be put into place.		
					The Maintenance Direct		
					or designee, will document the		
					checks on TELS. Any		
I	1		ı		5551.0 511 1 EEG. 7 111y		

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Event ID:

1J7X21

Facility ID: 000456

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155490	B. WI	NG		06/11/	2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L		l	MAIN ST		
AMBASS	SADOR HEALTHCA	RE	CENTERVILLE, IN 47330				
	Г				T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
					deficiencies will be discussed		
					monthly as part of the Quality		
					Assurance and Performance		
					Improvement (QAPI) meeting.		
					5 By what date the systemi		
					changes for each deficiency w	411	
					be completed		
					06/20/2025		
K 0351	NEDA 404						
SS=E	NFPA 101	lo atallatico					
	Sprinkler System	- Installation					
Bldg. 01	D	1 :	17.0	2.5.1	4 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		06/04/0005
		on and interview, the facility	K 0	351	1 What corrective action(s)	WIII	06/24/2025
		ne ceiling construction in 1 of 4			be accomplished for those		
	_	ance with NFPA 13, Standard			residents found to have been		
		of Sprinkler Systems. NFPA 13,			affected by the deficient practi	ce	
		on 6.2.7.1 states plates,			On 06/24/2025, the		
		er devices used to cover the			Maintenance Director replaced	d the	
	_	d a sprinkler shall be metallic			drop ceiling panel around the		
		use around a sprinkler. This			sprinkler escutcheon located i	n	
	_	ould affect as many as 40			the corridor between resident		
		d 2 visitors within the building			rooms 109 and 110, eliminating	ıg	
	#1 compartment.				the annular space.		
					2 How other residents havi	ng	
	Findings include:				the potential to be affected by		
					same deficient practice will be		
		ons made during a tour of the			identified and what corrective		
		ility Administrator and the			action(s) will be taken		
		for on 06/11/25 at 1:12 p.m., the			40 residents and employ	ees	
	sprinkler head locat	ed in the building #1 corridor			have the potential to be affect	ed	
	between resident ro	om #109 and #110 had a loose			by the alleged deficient practic	e.	
	escutcheon showing	g approximately one-quarter			The Maintenance Director		
	inch of annular space	ce. Based on interview on			conducted an inspection of		
	06/11/25 at 1:14 p.r	n., the Maintenance Director			sprinkler heads in building #1	on	
	acknowledged the a	nnular space and advised that			06/24/2025 to ensure no other		
	he was checking the	ese daily as they have been			escutcheons were loose. No		
		es throughout the facility.			additional deficiencies were fo	und.	
		-			3 What measures will be p	ut	
	This finding was re	viewed with facility			into place and what systemic		
	1	he Maintenance Director at			changes will be made to ensu	re	

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

PRINTED: 06/25/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETE			ETED	
		155490	B. WI	NG		06/11/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			MAIN ST		
AMBASS	ADOR HEALTHCA	RE	CENTERVILLE, IN 47330				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the exit conference	on 06/11/25.			that the deficient practice does	s not	
					recur		
	3.1-19(b)				The facility has revised it		
					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	ı(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 Directo	or,	
					or designee, will conduct weel	κly	
					inspections of all sprinkler hea	ids	
					throughout the facility to ensur	·e	
					escutcheons are secure and n	Ю	
					annular spaces are present.		
					5 By what date the systemi		
					changes for each deficiency w	/ill	
					be completed		
					06/24/2025		
K 0000							
Bldg. 02							
	-	Recertification and State	K 0	000	DISCLAIMER STATEMENT:		
	•	vas conducted by the Indiana			Preparation and/or execution		
	•	Ith in accordance with 42 CFR			this plan of correction in gener	al,	
	483.90(a).				or this corrective action in		
					particular, does not constitute		
	Survey Date: 06/11	1/25			admission or agreement by thi	i S	
	Englists North of O	000454			facility of the facts alleged or		
	Facility Number: 0				conclusions set forth in this		
	Provider Number: AIM Number: 100				statement of deficiencies. The		
	Alivi Number: 100.	200 / JU			plan of correction and specific		
	At this I ifa Safate t	Code survey, Ambassador			corrective actions are prepare		
		nd not in compliance with			and/or executed in compliance		
	Treatmeare was four	na not in comphance with			with state and federal laws. Th	แร	

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

PRINTED: 06/25/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155490		(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 02	(X3) DATE SURVEY COMPLETED 06/11/2025	
	PROVIDER OR SUPPLIER SADOR HEALTHCARE	705 E N	ADDRESS, CITY, STATE, ZIP COD MAIN ST ERVILLE, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	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.		provider respectfully requests this 2567 Plan of Correction is considered the Letter of Cred Allegation of Compliance and requests a desk review in lieu post survey review on or after 24, 2025.	that pe ible u of a	
K 0351 SS=E Bldg. 02	NFPA 101 Sprinkler System - Installation				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155490		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/11/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
	Based on observation failed to maintain the buildings in accordate for the Installation of 2010 edition, Section escutcheons, or other annular space around or shall be listed for deficient practice of residents, 6 staff and #2 compartment. Findings include: Based on observation facility with the fact Maintenance Direct sprinkler head locat room #RH 13 had an approximately one-Based on interview Maintenance Direct space and advised the daily as they have be throughout the facility is such as soon as	on and interview, the facility are ceiling construction in 1 of 4 ance with NFPA 13, Standard of Sprinkler Systems. NFPA 13, on 6.2.7.1 states plates, or devices used to cover the d a sprinkler shall be metallic arouse around a sprinkler. This could affect as many as 40 d 2 visitors within the building does not not on 06/11/25 at 1:36 p.m., the ed in the building #2 resident loose escutcheon showing that inch of annular space. On 06/11/25 at 1:37 p.m., the or acknowledged the annular mat he was checking these een replacing ceiling tiles ity and that he would address a possible.	K 035	-	1 What corrective action(s) be accomplished for those residents found to have been affected by the deficient practic On 06/20/2025, the Maintenance Director replaced escutcheon located in resident room RH13, eliminating the annular space. 2 How other residents having the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken 40 residents and employ have the potential to be affected by the alleged deficient practice by the alleged deficient practice. The Maintenance Director conducted an inspection of sprinkler heads in building #2 06/20/2025 to ensure no other escutcheons were loose. No additional deficiencies were fo 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does recur The facility has revised if fire alarm system maintenance protocol to include an ongoing weekly check of escutcheons appropriate annular space, effective 06/20/2025. 4 How the corrective action 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 appropriate in the program will be put into place. The Maintenance Director in the maintenance of the maint	the transfer of the transfer o	06/20/2025

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Event ID:

1J7X21

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 06/11/2025
	PROVIDER OR SUPPLIER		705 E	ADDRESS, CITY, STATE, ZIP COD MAIN ST ERVILLE, IN 47330	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				or designee, will conduct we inspections of all sprinkler he throughout the facility to ense scutcheons are secure and annular spaces are present. By what date the syster changes for each deficiency be completed 06/20/2025	eads ure no nic
K 0000					
Bldg. ID	Licensure Survey w Department of Heal 483.90(a). Survey Date: 06/11 Facility Number: 0 Provider Number: 100 At this Life Safety 0 Healthcare was four Requirements for P Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (L Care Occupancies a This two-story facil consists of four atta a one-story building through 120 and Re two-story section of partial basement. Bi	288750 Code survey, Ambassador and not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the cition Association (NFPA) 101, and SC) Chapter 19, Existing Health	K 0000	DISCLAIMER STATEMENT: Preparation and/or execution this plan of correction in gen- or this corrective action in particular, does not constitut admission or agreement by t facility of the facts alleged or conclusions set forth in this statement of deficiencies. Th plan of correction and specif corrective actions are prepar and/or executed in complian with state and federal laws. provider respectfully request this 2567 Plan of Correction considered the Letter of Crec Allegation of Compliance and requests a desk review in lie post survey review on or afte 24, 2025.	n of eral, e an his e ic ed ce This s that be dible d

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

Event ID:

1J7X21

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	· /	JLTIPLE CO	ID	(X3) DATE COMPL	ETED	
		155490	B. WI	NG		06/11/	2025	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0363 SS=E Bldg. ID	and is a one-story b basement. Building consisting of Room 302 through 313. E and was determined construction and wa The facility has a findetection in the correction and on all I basement in the wesfacility has battery or resident sleeping rocapacity of 137 and time of this visit. Quality Review con NFPA 101 Corridor - Doors							
	failed to ensure 1 of doors were provided keeping the door closing or latching, of smoke by latchin deficient practice of and 2 visitors in the Findings include: Based on observation facility with the fact Maintenance Direct corridor door to resign to the door frame on interview on 06/Maintenance Direct	on and interview, the facility 6.82 resident room corridor d with a means suitable for osed, had no impediment to and would resist the passage g into the door frame. This ould affect 20 residents, 2 staff building #4 compartment. Ons made during a tour of the ility Administrator and the or on 06/11/25 at 2:10 p.m., the ident room #217 failed to latch after multiple attempts. Based 11/25 at 2:12 p.m., the or acknowledged the ridor door stating that he	K 0.	363	1 What corrective action(s) be accomplished for those residents found to have been affected by the deficient praction. The Maintenance Direct repaired the corridor door to resident room #217 to ensure latches securely into the door frame. This included inspectin and adjusting the door latch, splate, and hinges as needed. 2 How other residents having the potential to be affected by 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	ice or it g strike ng the	06/20/2025	

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

PRINTED: 06/25/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155490		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>ID</u> B. WING		(X3) DATE SURVEY COMPLETED 06/11/2025	
	PROVIDER OR SUPPLIE		705 E	ADDRESS, CITY, STATE, ZIP COD MAIN ST ERVILLE, IN 47330	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	would attempt to fi	x the door as soon as possible. eviewed with facility the Maintenance Director at		resident room corridor doors werified to latch properly in compliance with K363 requirements. Any additional doors found to be non-compliance were repaired. 3 What measures will be provided into place and what systemic changes will be made to ensure that the deficient practice does recur The Maintenance Director will inspect proper door maintenance, including checking for latching mechanisms, alignment, and hardware integrated. 4 How the corrective action 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 to monthly to ensure proper latch of corridor doors. Any deficien will be discussed monthly as profit the Quality Assurance and Performance Improvement (Quality Assurance and Perform	vere ant ut re s not or ng prity. ask ning cies part API) c

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