STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155361	A. BUILDING -- B. WING	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMBER MANOR CARE CENTER	801 E ILLINOIS ST PETERSBURG, IN 47567

(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: 07/23/24 Facility Number: 000252 Provider Number: 155361 AIM Number: 100267780 At this Emergency Preparedness survey, Amber Manor Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 64 certified beds, with a current census of 53. Quality Review completed on 07/25/24	E 0000	The submission of this Plan of Correction does not indicate an admission by Amber Manor Care Center that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of Amber Manor Care Center. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety Code Survey on 07/23/2024. The facility respectfully requests from the department a desk review for substantial	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cindi Lents	HFA Executive Director	08/07/2024

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.

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			compliance.	
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: 07/23/24 Facility Number: 000252 Provider Number: 155361 AIM Number: 100267780 At this Life Safety Code survey, Amber Manor Care Center 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 one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 64 and had a census of 53 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 07/25/24	K 0000	The submission of this Plan of Correction does not indicate an admission by Amber Manor Care Center that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of Amber Manor Care Center. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety Code Survey on 07/23/2024. The facility respectfully	

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			requests from the department a desk review for substantial compliance.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of at least 10 hazardous area doors, such as an oxygen storage/transfilling room door, would latch into its door frame. This deficient practice could affect at least 20 residents, staff, and visitors in the east hall. Findings include: Based on observations on 07/23/24 between 11:45 a.m. and 1:30 p.m. during a tour of the facility with the Director of Plant Operations (DPO), the oxygen storage/transfilling room door to the corridor would not latch into its door frame after several attempts. There were five liquid oxygen tanks and over 10 oxygen cylinders stored in the room at the time of observation. Based on interview at the time of observation, the DPO acknowledged the oxygen room door to the corridor did not latch into its door frame. This finding was reviewed with the Executive Director and DPO during the exit conference. 3.1-19(b)	K 0321	K 321 Hazardous Areas-Enclosure The Director of Plant Operations immediately ensured the self-closing device was functioning properly. All residents and staff have the potential to be affected and therefore to ensure compliance, all doors with self-closing devices were checked and found to be working correctly. The Director of Plant Operation was educated by the Executive Director on K 321 Hazardous Areas – Enclosure. Proper operation of the oxygen storage room door will be monitored daily x 1 week. Then all doors with self-closing devices will be monitored weekly through our TELS system. Results of these audits will be presented by the Executive Director to the QAPI committee for further	08/12/2024

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			recommendation and continue until the Quality Assurance Team determines substantial compliance achieved.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 1 of 1 fire department connection was in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all occupants. Findings include: Based on observations on 07/23/24 between 11:45 a.m. and 1:30 p.m. during a tour of the facility with the Director of Plant Operations (DPO), the facility's fire department connection (FDC) was located on the west side of the facility. There was no FDC signage provided at the fire department	K 0353	K 353 Sprinkler System-Maintenance and Testing The Director of Plant Operations immediately purchased and installed signage to easily identify the FDC. All residents and staff have the potential to be affected and therefore to ensure compliance, all sprinkler system signage was audited and placement ensured. The Director of Plant Operations was educated by the Executive Director on Sprinkler System -Maintenance and Testing. The Director of Plant Operations will audit signage placement 1x per week for 1 month, then monthly for 3 months. Results of this audit will be presented by the Executive Director to the QAPI committee for further	08/12/2024

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	connection, furthermore, there was no FDC signage at the front of the building for the responding fire department to lead them to the FDC for easy identification. Based on interview at the time of observation, this was acknowledged by the DPO who agreed there should be FDC signage at the FDC and the front of the facility. This finding was reviewed with the Executive Director and DPO during the exit conference. 3.1-19(b)		recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 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 deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 07/23/24 between 11:45 a.m. and 1:30 p.m. during a tour of the facility with the Director of Plant Operations (DPO), the set of smoke barrier doors at the south end of the west corridor had a 1/4 inch gap between the doors when closed fully. This was acknowledged by the DPO at the time of observation, who further said the set of smoke barrier doors were installed about six months ago.	K 0374	K 374 Subdivision of Building Spaces - Smoke Barrier The Director of Plant Operations installed a smoke door seal leaving only the minimum clearance necessary for proper operation. All staff and residents could be affected and therefore to ensure compliance, all fire doors were audited to ensure only minimum clearance necessary for proper operation. The Director of Plant Operations was	08/12/2024

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	This finding was reviewed with the Executive Director and DPO during the exit conference. 3.1-19(b)		educated by Divisional Support on K374 smoke barrier doors would restrict movement of smoke for at least 20 mins as it pertains to NFPA 101 2012 19.3.7.6 19.3.7.8, 19.3.7.9 in compliance with LSC Section 8.5.4, L SC 8.5.4.1 The Director of Plant Operations will visually inspect the corridor doors weekly. The Executive Director will present the results of the audit to the QAPI Committee for further recommendations and will continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 2 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include:	K 0712	K 712 Fire Drills The Director of Plant Operations was immediately trained regarding the required varied times of fire drills and a fire drill was conducted on	08/12/2024

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	Based on review of the facility's fire drill reports on 07/23/24 between 9:00 a.m. and 11:45 a.m. with the Director of Plant Operations (DPO) present, the following was noted: a. 3 of 4 second shift (evening) fire drills were performed between 2:10 p.m. and 2:35 p.m. b. 4 of 4 third shift (night) fire drills were performed between 4:45 a.m. and 5:35 a.m. Based on interview at the time of record review, the DPO acknowledged the times of the second and third shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Executive Director and DPO during the exit conference. 3.1-19(b) 3.1-51(c)		second shift at 5:30 p.m. All residents and staff have the potential to be affected therefore as a measure of compliance the fire drills were reviewed. The Director of Plant Operations was educated by the Executive Director on the requirements of NEPA 101 concerning fire drills are to be held various times and dates to ensure conditions of drills to be conducted on unexpected days and unpredictable days under varying conditions at least quarterly on each shift. A schedule of fire drills was created for the next year (August 2024 to August 2025) to ensure the requirements for varying times and days will be met. The Executive Director and the Director of Plant Operations will present information to the QAPI committee for further recommendations and will continue until	

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			the Quality Assurance Team determines substantial compliance has been achieved	