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	11/07/2019

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 State Department of Health in accordance with 42 CFR 483.73. Survey Date(s): 11/06/19 & 11/07/19 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 122. Quality Review completed on 11/13/19	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date(s): 11/06/19 & 11/07/19 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	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 ID 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 122 at the time of this visit. All areas where residents have customary access were sprinkled except for the shower room by the east Dining Room and all areas providing facility services were sprinkled except for the vertical opening for HVAC ductwork in the basement for Building 03. Quality Review completed on 11/13/19			
K 0311 SS=E	NFPA 101 Vertical Openings - Enclosure			

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Bldg. 01	Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to maintain protection of 1 of 2 stairways in accordance of 19.3.1. LSC 19.3.1.1 requires where an enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. This deficient practice could affect over 5 residents, staff and visitors in the west wing of Building 01. Findings include: Based on observations with the Maintenance Supervisor and the Administrator during a tour of the facility from 9:30 a.m. to 12:25 p.m. on 11/07/19, the west wing west stairwell doors on the first and second floors each did not have an affixed fire resistance rating label. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned stairwell doors did not have a fire resistive label to confirm at least a forty five minute fire resistance rating. 3.1-19(b)	K 0311	K 311 VERTICAL OPENINGS ENCLOSURE I. West wing stairwell doors on the first and second floors will be replaced. They were found to have fire rating stickers however, they had been painted over and removal of the paint makes the fire rating unreadable. II. Residents of the West Unit have been identified as having the potential to be affected. III. Corrective action will include Scott Door Service will replace existing doors with 2 – 3068 RH 90- minute label doors by Masonite on existing frames with lever locks and door closures. Doors have been ordered and installation is estimated to be completed by 12/20/2019. Education provided to Maintenance Staff that fire rating	12/20/2019

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			labels must remain uncovered and legible on all fire doors. Instruction was given that if door required to be painted the label was not to be painted over. No other fire doors were found to be without a fire rating label. IV. Maintenance Supervisor will continue to instruct maintenance staff when maintenance is scheduled to fire doors that fire rating labels are to remain intact and legible. Maintenance Supervisor will oversee all maintenance to fire doors to ensure compliance. All newly installed fire doors will be inspected for proper fire rating labeling and corrected upon installation if not present. Expected Completion Date: December 20, 2019	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that			

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	do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 10 of 24 hazardous areas such as fuel fired heater rooms and soiled linen and trash collection rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor and the Administrator during a tour of the facility from 9:30 a.m. to 12:25 p.m. on 11/07/19, the following was noted: a. the door to the natural gas fired furnace room in the breakroom by the kitchen was equipped with a self closing device but the door failed to self close and latch into the door frame when tested to close multiple times. The face of the door kept hitting	K 0321	K 321 HAZARDOUS AREAS - ENCLOSURE I. Fuel fired heater room doors will contain a self-closure and demonstrate ability to close. Fuel fired furnace closets in rooms RH3 to RH10 will be equipped with steel furnace doors made by Masonite with wood frames, weather seals for smoke, lever locks and automatic door closures. Dutch door in North Kitchen will have a proper self-closing device. II. Residents of the East Unit and North Dining Area have been identified as having the potential to be affected.	02/20/2020

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AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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	the door frame on the door handle side of the door when tested to close multiple times which prevented the door to self close and latch into the door frame. b. the corridor door to resident rooms RH3 through RH10 were each not equipped with a self closing device. A natural gas fired furnace was located inside a closet in each of the resident rooms. The closet door was not equipped with a self closing device and the door had louvers from near the floor to near the top of the door which would not resist the passage of smoke. c. the Dutch door to the kitchen from the north Dining Room was equipped with a self closing device but the arm for the closing device was detached from the door. A wall mounted magnetic hold open device was also provided for the Dutch door to self close with fire alarm system activation. Three 44 gallon soiled linen and trash carts were noted in the kitchen. Due to the arm for the self closing device being detached from the door, the Dutch door to the kitchen failed to self close and latch into the door when tested to close multiple times. Based on interview at the time of the observations, the Administrator stated resident rooms RH3 through RH10 had been apartments and the natural gas fired furnaces have been in the rooms for many years. The Maintenance Supervisor stated the Dutch door was recently installed, the installation may not yet have been completed but agreed the aforementioned hazardous areas were not separated from other spaces by smoke resistant partitions and doors. 3.1-19(b)		III. Corrective action will include on 11/15/2019 Maintenance staff adjusted door to the fuel fired furnace room in the breakroom near the kitchen to ensure proper closure with automatic door closure installed. Door automatically closed into door frame when tested several times. Scott Door Service will replace existing 4ft Dutch Door in North Dining area. This door was installed recently and has a manufacturer defect. Manufacturer has been contacted by Scott Door Service for replacement door and door has been ordered. Manufacturer has not yet estimated delivery date for new door. Scott Door service has been contracted to replace existing louvered furnace closet doors in RH3 to RH10 with a steel furnace door by Masonite with wood frames, weather seals for smoke, lever locks and automatic door closures. Replacement is scheduled to begin on 12/16/2019 and estimated completion date is 12/20/2019. Automatic door closures will be tested monthly to ensure all automatic closures are functioning properly and all doors have the ability to close completely into door frame. Any door found to not close completely into door frame will be immediately rectified and door closure will be ensured.	

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			IV. Results of these audits will be discussed at facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Expected Completion Date: Waiver Requested. Revised Waiver Uploaded	
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 17.5.3.1 states total smoke detector coverage shall include basements. This deficient practice could affect over 5 residents, staff and visitors in the west wing of Building 01. Findings include:	K 0341	K 341 FIRE ALARM SYSTEM - INSTALLATION I. Koorsen Fire Protection Services was contacted on 12/5/2019 to initiate installation of two wired smoke detectors in the west basement. II. The residents and	12/13/2019

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	Based on observations with the Maintenance Supervisor and the Administrator during a tour of the facility from 9:30 a.m. to 12:25 p.m. on 11/07/19, the basement of the west wing in Building 01 was not provided with smoke detector coverage. Based on interview at the time of the observations, the Maintenance Supervisor agreed the the basement was not provided with smoke detector coverage. 3.1-19(b)		staff of the west unit are identified as having the potential to be affected. III. Corrective action included installing two wired smoke detectors in the west basement. Installation to begin on 12/10/2019. Ongoing, the smoke detectors will be included in the routine smoke detector maintenance performed by Koorsen Fire Protective Services and checked accordingly for proper function. IV. The preventative maintenance logs will be reviewed by the Administrator and any identified issues will be discussed and reviewed during QA Meetings. Completion Date: December 13, 2019	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance			

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	and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 10.5.5.1 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. Section 10.5.5.4 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The dedicated branch circuit(s) and connections shall be protected against physical damage. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:40 p.m. to 3:00 p.m. on 11/06/19, access to the fire alarm system breaker located in the electrical panel in the corridor near Room 202 was not restricted to authorized personnel. Circuit #14 in the panel was identified as "Fire Alarm Panel" and did not have a red marking, was not accessible only to authorized personnel and was not identified as "fire alarm circuit". Based on interview at the time of the observations, the Maintenance Supervisor agreed access to the fire alarm system breaker was not restricted to authorized personnel, did not have a red marking and was not identified as fire	K 0345	K 345 FIRE ALARM SYSTEM – TESTING AND MAINTENANCE I. Fire Alarm System will be protected against unauthorized access by installing a lock on the electrical panel. “Fire Alarm Circuit” will be properly identified and contain a red marking. II. All residents were identified as having the potential to be affected. III. Corrective action will include proper identification and labeling of “Fire Alarm Circuit”. On 11/25/19 a lock was placed on all electrical panels in each corridor including the one containing the “Fire Alarm Circuit” to restrict access to only authorized personnel. Koorsen Fire Protection to verify correct circuit for “Fire Alarm Circuit” and ensure circuit is properly labeled. Verification is scheduled for December 9, 2019 with estimated completion date of December 15, 2019 IV. “Fire Alarm Circuit” electrical panel will remain locked at all times. Visual inspection of electrical panels will be completed monthly and any missing or damaged locks will be	12/15/2019

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	alarm circuit. 3.1-19(b)		immediately repaired or replaced. The results of these audits will be discussed at facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: December 15, 2019	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility failed to ensure the automatic sprinkler system provided complete coverage in 1 of over 3 shower rooms and in 1 of 1 vertical openings in the basement of Building 03. This deficient practice	K 0351	K 351 SPRINKLER SYSTEM – INSTALLATION I. Identified sprinkler heads will be installed in all areas.	12/15/2019

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	could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor and the Administrator during a tour of the facility from 9:30 a.m. to 12:25 p.m. on 11/07/19, the following was noted: a. the shower room by the East Dining Room was not sprinklered. b. the vertical opening in the basement for Building 03 housing the vertical HVAC duct was not sprinklered. Based on interview at the time of the observations, the Maintenance Supervisor and the Administrator stated the shower room was recently renovated but agreed the aforementioned two areas were not provided with sprinklers. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the spray pattern for 1 of over 100 automatic sprinklers was not obstructed in accordance with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect over 5 residents, staff and visitors in the west wing in Building 01.		West nurse's station wall will be reduced to give at least 18" clearance from sprinkler head. Bracket will be installed no more than 24" from the end of the identified armover. II. Residents of the West, East and 600 Units have been identified as having the potential to be affected. III. Corrective action has included Koorsen Fire Protection has been contacted to install a sprinkler head in the East shower room and in the 600 hall basement HVAC vertical opening. Koorsen will also add a bracket to the end of the armover in the west stairwell that will not extend beyond 24" from the end of the armover. Installation has been scheduled to begin on 12/9/2019. On 11/25/2019 maintenance staff removed the top portion of the partial wall at the west nurse's station. Upon completion the distance from ceiling was extended from 10" to 20" from the sprinkler deflector. IV. Sprinkler system will continue to be checked and inspected as currently scheduled and identified issues will be corrected accordingly.	

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	155490	A. BUILDING 01 B. WING	11/07/2019

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	Findings include: Based on observations with the Maintenance Supervisor and the Administrator during a tour of the facility from 9:30 a.m. to 12:25 p.m. on 11/07/19, the ceiling mounted sprinkler located in the corridor near the nurse's station in the west wing of Building 01 had automatic sprinkler head spray pattern obstruction within 18 inches below the sprinkler deflector. The nurse's station was not provided with an automatic sprinkler. The nurse's station had a partial see through privacy wall constructed which extended to within ten inches of the ceiling and provided spray pattern obstruction for the corridor sprinkler location. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned automatic sprinkler location had spray pattern obstruction. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure steel armover sprinkler pipes at 1 of 1 locations in the west wing stairwell of Building 01 was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, at 9.2.3.5.1 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect over 5 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor and the Administrator during a tour of the facility from 9:30 a.m. to 12:25 p.m. on 11/07/19,		Completion Date: December 15, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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	the steel sprinkler pipe near the west stairwell ceiling in the west wing of Building 01 had a 48 inch horizontal armover to a sprinkler which was unsupported. Based on interview at the time of the observations, the Maintenance Supervisor stated the armover has been like that since the sprinkler pipe was installed but agreed an unsupported sprinkler pipe armover was noted at the aforementioned location. 3.1-19(b)			
K 0352 SS=F Bldg. 01	NFPA 101 Sprinkler System - Supervisory Signals Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 Based on observation and interview, the facility failed to maintain automatic sprinkler systems in accordance with LSC 9.7. LSC 19.3.5.1 states buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. LSC 9.7.2.1 states where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either	K 0352	K 352 SPRINKLER SYSTEM – SUPERVISORY SIGNALS I. Tamper will be installed on Post Indicator Valve (PIV) outside facility near the dumpsters. II. All residents have been identified as having the potential to be affected. III. Corrective action has included Koorsen Fire Protection has been contacted to install a tamper on the Post Indicator Valve	12/15/2019

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	155490	A. BUILDING 01 B. WING	11/07/2019

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	at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 9:30 a.m. to 12:25 p.m. on 11/07/19, the Post Indicator Valve (PIV) located outside the facility near the dumpsters on the west side of the building was not electrically supervised. Based on interview at the time of the observations, the Maintenance Supervisor agreed the PIV was not electrically supervised. 3.1-19(b)		(PIV) located outside the facility near the dumpsters on the west side of the building. Installation is scheduled to begin on 12/9/2019. IV. Sprinkler system will continue to be checked and inspected as currently scheduled and identified issues will be corrected accordingly. Completion Date: December 15, 2019	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.			

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	9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 3 of 3 sprinkler heads loaded with a foreign material were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:40 p.m. to 3:00 p.m. on 11/06/19 and from 9:30 a.m. to 12:25 p.m. on 11/07/19, the following was noted: a. two of two sprinkler heads in the Laundry behind the dryers were loaded with lint. b. the sprinkler located on the ceiling in the bathroom by the East Dining Room had its plastic protective shipping and storage cover which	K 0353	K 353 SPRINKLER SYSTEM -MAINTENANCE AND TESTING I. Identified sprinklers in Laundry area were cleaned of lint upon discovery. Plastic protective shipping and storage cover was removed immediately when identified. II. Residents staff and visitors of the East Unit and Laundry staff were identified as being potentially affected. III. Corrective action will include sprinkler heads in laundry area will be added to a weekly visual inspection routine maintenance scheduled due to increased probability of being exposed to dust, dirt, debris and lint. All sprinkler heads found to be out of compliance will be cleaned, repaired or replaced immediately as appropriate. Laundry and Maintenance staff were educated on sprinkler maintenance and new procedure to inspect sprinkler heads in the laundry area on 11/25/2019. IV. Results of these audits will be discussed at facility Quality Assurance Performance Improvement meeting and frequency and duration of review will be adjusted as needed.	11/25/2019

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	protects the glass bulb for the sprinkler still installed on the sprinkler. Based on interview at the time of the observations, the Maintenance Supervisor stated he regularly cleans the Laundry sprinklers but does not document the cleaning. The Maintenance Supervisor also stated the bathroom and the shower room near the East Dining Room were recently renovated and removed the cover for the sprinkler but agreed the aforementioned automatic sprinklers were loaded with a foreign material. 3.1-19(b)		Completion Date: November 25, 2019	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that			

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	release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 10 of over 75 corridor doors had no impediment to closing, latching and would resist the passage of smoke. LSC Section 19.3.6.3.13 states Dutch doors shall be permitted where they conform to 19.3.6.3 and meet all of the following criteria: (1) Both the upper leaf and lower leaf are equipped with a latching device. (2) The meeting edges of the upper and lower leaves are equipped with an astragal, a rabbet, or a bevel. (3) Where protecting openings in enclosures around hazardous areas, the doors comply with NFPA 80, Standard for Fire Doors and Other Opening Protectives. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance	K 0363	K 363 CORRIDOR - DOORS I. Trash can was removed upon discovery from doorway of Room RH1. Cubicle Curtain tracks in rooms RH3 to RH10 are being relocated to eliminate curtain impeding door closure. An astragal was installed on the Dutch Door of the South Kitchen. II. Residents in rooms RH3 thru RH10 and South unit residents were identified as having the potential to be affected. III. Corrective action will include resident and staff education as to the importance of not impeding door closure by propping doors open with heavy	12/15/2019

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AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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	Supervisor during a tour of the facility from 1:40 p.m. to 3:00 p.m. on 11/06/19 and from 9:30 a.m. to 12:25 p.m. on 11/07/19, the following was noted: a. a trash can was used to prop the corridor door to resident Room RH1 in the fully open position. b. the track mounted on the ceiling for the cubicle curtain near the corridor door in Rooms RH3 through RH10 allows the cubicle curtain in the room to pass within the swinging path of the corridor door. With the cubicle curtain drawn, an impediment was noted to closing and latching the corridor door to each room when tested to close the doors multiple times. c. the meeting edges of the upper and lower leaves for the Dutch door to the kitchen by Room 303 was not provided with an astragal, a rabbet, or a bevel. A one quarter inch gap was noted in between the meeting edges of the upper and lower leaves. The Dutch door is a corridor door to the kitchen. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned corridor doors each had an impediment to closing, latching and would not resist the passage of smoke. 3.1-19(b)		objects. An astragal was installed on the Dutch Door to the South Kitchen on 11/15/2019. Maintenance Staff began relocation of Privacy Curtain tracks in Rooms RH3 to RH 10 on 11/26/2019. Additional track needed to be ordered to complete all rooms. Estimated date of completion is 12/15/2019. Continue periodic education to staff and residents regarding impeding door closure. Monthly door closure checks will be completed by Department Head staff. IV. Results of these checks will be discussed at facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: December 15, 2019	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure all electrical panels in the	K 0511	K 511 UTILITIES – GAS AND ELECTRIC	11/25/2019

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	155490	A. BUILDING 01 B. WING	11/07/2019

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

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	corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:40 p.m. to 3:00 p.m. on 11/06/19 and from 9:30 a.m. to 12:25 p.m. on 11/07/19, the following electrical panel locations in the corridor were each not locked: a. by Room 2 in the west wing. b. by the west wing exit door. c. the two electrical panels across from the Administrator's Office. d. by Room RH3. e. by Room 109. f. by Room 112. g. by Room 202. h. by Room 303. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned electrical panels in the corridor were not secured from non-authorized personnel.		I. On 11/25/2019 all electrical panels in corridors were equipped with locks to prevent unauthorized personnel from use. II. All residents, staff and visitors were identified as being potentially affected. III. Corrective action included locks being installed on all electrical panels in corridors. Maintenance personnel will conduct visual inspection of electrical panels to ensure locks are present and immediately repair or replace any locks as needed. IV. Results of these inspections will be discussed at facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: November 25, 2019	

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	11/07/2019

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	3.1-19(b)			
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 8 of 8 natural gas fired furnaces in Building 02 were provided with combustion air taken directly from the outside. This deficient practice could affect 10 residents, staff and visitors in rooms RH 1 through RH10 in Building 02. Findings include: Based on observations with the Maintenance Supervisor and the Administrator during a tour of the facility from 9:30 a.m. to 12:25 p.m. on 11/07/19, a natural gas fired furnace was located inside a closet in each of resident rooms RH3 through RH10. The furnaces were not continually provided with combustion air supply taken directly from the outside when in operation. Based on interview at the time of the observations, the Administrator stated resident rooms RH3 through RH10 had been apartments and the natural gas fired furnaces have been in	K 0522	K 522 HVAC - ANY HEATING DEVICE I. Bader Mechanical Services has been reserved to install make-up air systems to each of the 8 furnaces in rooms RH3 to RH10. II. Ventilator Hall residents have been identified as having the potential to be affected. III. Corrective action will include proper installation of a make-up air system for each of the 8 furnaces located 1 in each room of RH3 to RH10. Service has been retained and parts have been ordered. Part to arrive and work to begin on 12/16/2019. Due	01/04/2020

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	155490	A. BUILDING 01 B. WING	11/07/2019

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

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	the rooms for many years but agreed the natural gas fired furnaces were not continually provided with combustion air supply taken directly from the outside when in operation. 3.1-19(b)		to complexity of installation and limited space on the ventilator unit, expected completion of this project is 1/4/2020. IV. Administrator and Maintenance Supervisor will work closely with Bader Mechanical Services to ensure that all work is completed as planned. No other furnaces were found to not be supplied with make-up air. Any future furnace installation will be complete with a make-up air system. Expected Completion Date: January 4, 2020	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. on the second shift for 1 of 4 quarters. LSC 19.7.1.4 states fire drills in health care occupancies shall include the transmission of	K 0712	K 712 FIRE DRILLS I. Maintenance Supervisor to conduct all fire drills in accordance with Life Safety Requirements. All fire drills held	12/07/2019

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	155490	A. BUILDING 01 B. WING	11/07/2019

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	the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with Maintenance Supervisor during record review from 9:40 a.m. to 1:40 p.m. on 11/06/19, documentation for the second shift fire drill conducted on 02/20/19 at 8:00 p.m. stated "coded drill" in response to "Fire Alarm Activation Method" and was left blank in response to "Fire alarm system tested". Based on interview at the time of record review, the Maintenance Supervisor stated the facility operates three shifts per day, the fire drill was conducted as a silent drill and agreed the aforementioned second shift fire drill documentation did not include activation of the fire alarm system and transmission of the fire alarm signal for fire drills conducted after 6:00 a.m. and before 9:00 p.m. 3.1-19(b) 2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report"		between 6a-9p will have fire alarm sounded. All fire drills will be conducted at expected and unexpected times and under varying conditions. II. All residents and staff are identified as having the potential to be affected. III. Corrective action will include education provided to Maintenance Supervisor as to requirements for Fire Drill compliance under Life Safety Code. Ongoing, all fire drills will be completed following guidelines set forth in Life Safety Code. Random times will be selected by the Administrator. Administrator to review Fire Drill Logs. Any drill found to be out of compliance will be repeated in an acceptable time frame for compliance. Retraining will be provided as necessary. IV. Results of these audits will be discussed in facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: December 7, 2019	

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	11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	documentation with Maintenance Supervisor during record review from 9:40 a.m. to 1:40 p.m. on 11/06/19, third shift fire drills conducted on 12/30/18, 03/07/19 and 09/16/19 were conducted at, respectively, 2:00 a.m., 2:00 a.m. and 2:30 a.m. Based on interview at the time of record review, the Maintenance Supervisor stated the facility operates three shifts per day and agreed the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)			
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure all circuits on the critical branch supply power to critical branch functions related to patient care in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.2.2.4.2 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states the critical branch shall supply power for task illumination, fixed equipment, select receptacles, and select power circuits serving the following areas and functions related to patient care: (1) Critical care areas that utilize anesthetizing gases, task illumination, select receptacles, and	K 0911	K 911 ELECTRICAL SYSTEMS - OTHER I. Bader Mechanical Services has been reserved to install a new hospital grade receptacle not tied into the critical branch circuit for the sump pump in the west basement. II. Residents of the West Unit have been identified as having the potential to be affected.	12/20/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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	fixed equipment (2) Isolated power systems in special environments (3) Task illumination and select receptacles in the following: (a) Patient care rooms, including infant nurseries, selected acute nursing areas, psychiatric bed areas (omit receptacles), and ward treatment rooms (b) Medication preparation areas (c) Pharmacy dispensing areas (d) Nurses' stations (unless adequately lighted by corridor luminaries) (4) Additional specialized patient care task illumination and receptacles, where needed (5) Nurse call systems (6) Blood, bone, and tissue banks (7) Telephone equipment rooms and closets (8) Task illumination, select receptacles, and select power circuits for the following areas: (a) General care beds with at least one duplex receptacle per patient bedroom, and task illumination as required by the governing body of the health care facility (b) Angiographic labs (c) Cardiac cathertization labs (d) Coronary care units (e) Hemodialysis rooms or areas (f) Emergency room treatment areas (select) (g) Human physiology labs (h) Intensive care units (i) Postoperative recovery rooms (select) (9) Additional task illumination, receptacles, and select power circuits needed for effective facility operation, including single-phase fractional horsepower motors, which are permitted to be connected to the critical branch. Section 6.4.2.2.6.1 states the critical branch shall be kept independent of all other wiring and equipment.		III. Corrective action will include Bader Mechanical Services will install a new hospital grade 10-2 MC cable from non-emergency panel in west building to basement sump pump, install a new surface mounted box with 20 amp receptacle, provide a new 20 amp breaker, and install fire stop to all holes made for MC cable. Installation has been scheduled to begin on 12/16/2019 with an estimated completion date of 12/20/2019. IV. Administrator and Maintenance Supervisor will work closely with Bader Mechanical Services to ensure that all work is completed as planned. No other non-emergent equipment was found to be wired to the critical branch circuit. Expected Completion Date: December 20, 2019	

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	155490	A. BUILDING 01 B. WING	11/07/2019

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AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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	This deficient practice could affect 16 residents in Building 02. Findings include: Based on observations with the Maintenance Supervisor and the Administrator during a tour of the facility from 9:30 a.m. to 12:25 p.m. on 11/07/19, it could not be assured all dedicated circuits in electrical panels supply power to critical branch functions related to patient care. The electrical panel identified as "CP1" for critical branch circuits in the electrical room for Building 03 had a circuit identified as "sump pump plug" which is not a critical branch circuit related to patient care. The facility has vent units in rooms RH3 through RH10. Based on interview at the time of the observations, the Maintenance Supervisor agreed the sump pump plug is not a critical branch circuit. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For			

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	155490	A. BUILDING 01 B. WING	11/07/2019

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	LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents.	K 0914	K 914 ELECTRICAL SYSTEMS-MAINTENANCE AND TESTING I. On 12/4/2019 the facility Maintenance Supervisor will conduct an initial Annual Receptacle test of all receptacles in patient bed locations. The facility will check the physical integrity of each receptacle visually. The facility will check polarity of hot and neutral connections, grounding circuit and retention force (at least 4oz). II. All residents were identified as having the potential to be affected. III. Corrective action will include the initiation of annual receptacle testing of all non-hospital grade receptacles and initial recorded testing of all hospital grade receptacles in patient bed areas. Annual receptacle testing will be added to the scheduled preventative maintenance work orders to ensure compliance with further	12/15/2019

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	Findings include: Based on record review with Maintenance Supervisor from 9:40 a.m. to 1:40 p.m. on 11/06/19, documentation of an itemized listing of testing electrical outlet receptacles at patient bed locations within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated there is a mix of hospital grade and not hospital-grade receptacles in the resident sleeping rooms and stated documentation of an itemized listing of testing electrical outlet receptacles not listed as hospital-grade at patient bed locations within the most recent twelve month period was not available for review. In addition, documentation of an itemized listing of testing hospital grade electrical outlet receptacles at patient bed locations at initial installation was also not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 1:40 p.m. to 3:00 p.m. on 11/06/19 and from 9:30 a.m. to 12:25 p.m. on 11/07/19, all electrical receptacles installed at all patient bed locations in Building 01, Building 03 and Building ID were not hospital grade receptacles and all electrical receptacles installed at all patient bed locations in Building 02 in the RH Hall were hospital grade receptacles. 3.1-19(b)		testing requirements. Results of testing will be placed with Maintenance Logs. IV. Preventative Maintenance logs will be monitored by the Administrator and any errors will be corrected by the Maintenance Supervisor. Completion Date: December 15, 2019	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable			

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	155490	A. BUILDING 01 B. WING	11/07/2019

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AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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	of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on observation and interview, the facility failed to ensure overcurrent protective devices in Emergency Power Supply Systems (EPSS) circuits were accessible only to authorized persons. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 6.5.4 states overcurrent devices in EPSS circuits shall be accessible to authorized persons only. This	K 0918	K 918 ELECTRICAL SYSTEMS – ESSENTIAL ELECTRIC SYSTEMS I. Cabinet to transfer switch to generator will be locked. Emergency battery backup lighting will be installed at the	12/20/2019

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	deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor and the Administrator during a tour of the facility from 9:30 a.m. to 12:25 p.m. on 11/07/19, one of one emergency generator transfer switches located outside the facility within the enclosure for the emergency generator was in an unlocked cabinet. Based on interview at the time of the observations, the Maintenance Supervisor agreed the emergency generator transfer switch at the emergency generator location was unlocked. 3.1-19(b) 2. Based on observation and interview, the facility failed to provide emergency task generator battery backup lighting at 1 of 1 emergency generator locations. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include:		generator site. A 4 hour generator load test will be performed. II. All residents have been identified as having the potential to be affected. III. Corrective action will include on 11/25/2019 a lock was installed on the cabinet containing the transfer switch to the generator. A visual inspection of the lock will be performed during weekly generator test and repair or replacement will be completed as necessary. Bader Mechanical Services will install an emergency battery backup lighting system at the generator site. Parts have been ordered and work is scheduled to begin on 12/16/2019 and is estimated to be completed by 12/20/2019. A 4 hour load test was performed on 11/27/2019. Load testing will be added to a preventative maintenance schedule to be completed at least every 36 months. IV. Maintenance Supervisor will report findings to Administrator and results will be discussed at the facility Quality Assurance Performance Improvement meeting frequency and duration of reviews will be adjusted as needed. Expected Completion Date: December 20, 2019	

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	155490	A. BUILDING 01 B. WING	11/07/2019

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Based on observations with the Maintenance Supervisor during a tour of the facility from 9:30 a.m. to 12:25 p.m. on 11/07/19, battery backup lighting was not provided for the emergency generator located outside the facility in a three sided enclosure. Based on interview at the time of record review, the Maintenance Supervisor agreed battery backup lighting was not provided for the emergency generator location.

3.1-19(b)

3. Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all residents, staff and visitors.

Findings include:

Based on record review with Administrator and the Maintenance Supervisor from 9:40 a.m. to 1:40 p.m. on 11/06/19, documentation of a four hour load test conducted within the most recent 36 month period was not available for review. Based on interview at the time of record review, the Administrator stated the facility has vent units in the east hall in Building 02. Based on interview at

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	the time of record review, the Maintenance Supervisor stated a generator contractor performs semiannual maintenance on the generator but agreed a four hour load test was not conducted in the past 36 months. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 5 of 5 extension cords and multiplug adaptors were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to	K 0920	K 920 ELECTRICAL EQUIPMENT – POWER CORDS AND EXTENSION CORDS	11/25/2019

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	155490	A. BUILDING 01 B. WING	11/07/2019

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AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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	comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 50 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:40 p.m. to 3:00 p.m. on 11/06/19 and from 9:30 a.m. to 12:25 p.m. on 11/07/19, the following was noted: a. a refrigerator and a microwave oven were plugged into a multiplug adaptor which was plugged into a wall mounted outlet box in the breakroom outside the Laundry. b. an air mattress for the resident bed and a television were plugged into a power strip on the		I. Multiplug adapter was removed from Laundry and microwave and refrigerator were plugged into a wall outlet. Furniture in Room 4 was rearranged, and the power strip was able to be eliminated Bed and TV were plugged into a wall outlet. Power strip in room 104 was moved to extend 6 feet from resident bed. Furniture in Room 113 was rearranged, and power strip was eliminated. Multiplug adapter was removed from room 128 and TV and refrigerator were plugged into a wall outlet. Microwave and power strip were removed from the Therapy room and a microwave with a longer power cord was installed and plugged directly into a wall outlet. Power strip was removed from South Kitchen and microwave and toaster were plugged into a wall outlet. II. All residents from North and West units were identified as having the potential to be affected. III. Corrective action has included the removal of multiplug adapters and power strips. Remaining power strips with non PCREE have been relocated to a location that is at least 6 feet from resident bed area. An inspection of all new power strips will be conducted by the Administrator,	

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	155490	A. BUILDING 01 B. WING	11/07/2019

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AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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	floor under the resident bed nearest the window in Room 4. The UL listing of the power strip was 60601-1. c. the electric chair, a lamp and a light were plugged into a power strip three feet from the resident bed nearest the window in Room 104. The UL listing of the power strip was 60601-1. d. the resident bed, a fan and a television were plugged into a power strip on the floor within one foot of the resident bed nearest the window in Room 113. The UL listing of the power strip was 60601-1. e. a refrigerator and a DVD player were plugged into a multiplug adaptor in Room 128. f. a microwave oven and a toaster were plugged into a power strip on the floor in the south kitchen by Room 303. The UL listing of the power strip was 60601-1. g. a microwave oven was plugged into a power strip in the Therapy Room. Based on interview at the time of the observations, the Maintenance Supervisor agreed power strips and multiplug adaptors were being used in the patient care vicinity for PCREE and non-PCREE and as a substitute for fixed wiring at the aforementioned locations. 3.1-19(b)		Maintenance Supervisor or Designee to ensure compliance. Any power strips found to be out of compliance will be removed or relocated to a suitable area. Education provided on 11/25/2019 to both Laundry and Dietary staff in regard to LSC guidelines for use of power cord and extension cords. IV. Periodic checks of resident rooms will be completed to ensure compliance with power cord and extension cord policy. Results of these audits will be discussed at facility Quality Assurance Performance Improvement Meeting and frequency and duration of reviews will be adjusted as needed Completion Date: November 25, 2019	