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	12/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/13/22 Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750 At this Emergency Preparedness survey, Ambassador Healthcare was found not 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 88. Quality Review completed on 12/19/22	E 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. We are requesting a desk review for this survey.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Mantooth	Executive Director	12/30/2022

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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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency	E 0004	I. Emergency Preparedness Plan is scheduled	01/11/2023

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	Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 12/13/22 between 9:25 a.m. and 1:05 p.m., the EEP cover page did not have an annual update which was current. The last update to the EPP indicated on the cover page was 11/15/19 and no other date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Administrator stated that when she opened the EPP she noticed that an annual review had not been done indicating the EPP was updated within the last year. This finding was acknowledged by the Administrator and Maintenance Director at the time discovery and again at the exit conference.		to be reviewed on 1/5/2023 and follow up on 1/11/2023. II. All residents have been identified as having the potential to be affected. III. Corrective action will include EPP will be scheduled to be reviewed each year as a part of the QAPI Program. Current EPP will be reviewed and updated on 1/5/2023 and follow up completed on 1/11/2023. IV. QAPI Committee will be scheduled to review EPP on an annual and as needed basis.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based			

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	on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.			

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	*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 12/13/22 between 9:25 a.m. and 1:05 p.m., the EEP cover page did not have an annual update which was current. The last update to the EPP indicated on the cover page was 11/15/19 and no other date could be found to show EPP Policies and Procedures was reviewed and updated within the last year. Based on an interview during records review, the Administrator stated that when she opened the EPP she noticed that an annual review had not been done indicating the EPP was updated within the last year. This finding was acknowledged by the	E 0013	I. Policies and Procedures within the EPP are scheduled to be reviewed on 1/5/2023 and follow up on 1/11/2023. II. All residents have been identified as having the potential to be affected. III. Corrective action will include EPP will be scheduled to be reviewed each year as a part of the QAPI Program. Current EPP will be reviewed and updated on 1/5/2023 and follow up completed on 1/11/2023. IV. QAPI Committee will be scheduled to review EPP on an annual and as needed basis.	01/11/2023

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	Administrator and Maintenance Director at the time discovery and again at the exit conference.			
E 0015 SS=C Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.			

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	*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the	E 0015	I. Pharmacy Emergency Preparedness plan was located and placed in the Emergency Preparedness Plan Book on 12/27/2022. II. All residents and staff have been identified as having the potential to be affected. III. Corrective action will include EPP will be reviewed on 1/5/2023 with follow up on 11/11/2023 and annually thereafter. Outside contracting agency Emergency Preparedness Policies will be reviewed at that time.	01/11/2023

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	Administrator and the Maintenance Director on 12/13/22 between 9:25 a.m. and 1:05 p.m., the facility was unable to provide documentation for the policies for pharmaceutical supplies. Based on interview at the time of record review, the Administrator confirmed the provided documentation was incomplete. This finding was acknowledged by the Administrator and Maintenance Director at the time discovery and again at the exit conference.		IV. QAPI Committee meeting will be scheduled to review EPP on and annual and as needed basis.	
E 0018 SS=C Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are			

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	relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff			

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	responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants, Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 12/13/22 between 9:25 a.m. and 1:05 p.m., a policy and procedure that includes a system to track the location of sheltered residents in the LTC facility's care during and after an emergency was provided, but the policy did not provide an actual plan/system to track the resident and staff locations. The provided policy only stated "to	E 0018	I. Current policy on tracking staff and residents was reviewed and updated on 12/29/2022. II. All residents and staff have been identified as having the potential to be affected. III. Corrective action will include current policy updated to identify who will track staff and who will track residents and tracking logs have been added to the policy. IV. QAPI Committee will be scheduled to review EPP on an annual and as needed basis. Tracking of Staff and Residents policy will be reviewed at annual review.	01/11/2023

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	designate someone to track residents and someone to track staff." Based on interview at the time of record review then again at the exit conference, the Administrator confirmed a policy and procedure for tracking residents & staff was incomplete. This finding was acknowledged by the Administrator and Maintenance Director at the time discovery and again at the exit conference.			
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the	E 0029	I. Current communication plan will be reviewed on 1/5/2023 and follow up completed on 1/11/2023. II. All residents and staff have been identified as having the potential to be affected. III. Corrective action will	01/11/2023

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	Administrator and the Maintenance Director on 12/13/22 between 9:25 a.m. and 1:05 p.m., the EEP cover page did not have an annual update which was current. The last update to the EPP indicated on the cover page was 11/15/19 and no other date could be found to show EPP's Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator stated that when she opened the EPP she noticed that an annual review had not been done indicating the EPP was updated within the last year. This finding was acknowledged by the Administrator and Maintenance Director at the time discovery and again at the exit conference.		include current communication policy will be reviewed and updated as necessary on 1/5/2023 and follow up completed on 1/11/2023. IV. QAPI Committee will be scheduled to review EPP on an annual and as needed basis. Communication Policy will be reviewed at annual review.	
E 0031 SS=C Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local			

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	12/13/2022

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

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	emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan included all applicable sources of assistance. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 12/13/22 between 9:25 a.m. and 1:05 p.m., documentation of the communication plan part of the facility's emergency preparedness program reviewed did not include specific contact information, including telephone number, for notification of the State Long Term Care Ombudsman. The Administrator agreed documentation for the communication plan part of	E 0031	I. Current Emergency official contact list was reviewed and updated on 12/28/2022. State and Local Ombudsman contact information was added to the contact list. II. All residents and staff have been identified as having the potential to be affected. III. Corrective action will include Emergency Officials Contact Information list was updated on 12/28/2022. List will be updated periodically as changes to officials are recognized by the Administrator/Designee.	01/11/2023

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	the program did not include specific contact information for the office of the State Long Term Care Ombudsman. This finding was acknowledged by the Administrator and Maintenance Director at the time discovery and again at the exit conference.		IV. QAPI Committee will be scheduled to review EPP on an annual and as needed basis. Emergency Officials Contact Information will be reviewed at annual review and as changes are identified.	
E 0034 SS=C Bldg. --	403.748(c)(7), 416.54(c)(7), 418.113(c)(7), 441.184(c)(7), 482.15(c)(7), 483.475(c)(7), 483.73(c)(7), 484.102(c)(6), 485.625(c)(7), 485.68(c)(5), 485.727(c)(5), 485.920(c)(7), 491.12(c)(5), 494.62(c)(7) Information on Occupancy/Needs §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident			

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	155490	A. BUILDING -- B. WING	12/13/2022

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	Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 12/13/22 between 9:25 a.m. and 1:05 p.m., the provided EPP communication plan did not include the residents in the ventilator unit in their means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction or the Incident Command Center, or designee. This finding was acknowledged by the Administrator and Maintenance Director at the time discovery and again at the exit conference.	E 0034	I. Procedure was written for Communication and Coordination with Emergency Responders and Resources on 12/29/2022. II. All residents and staff have been identified as having the potential to be affected. III. Corrective action will include education of staff on new procedure for Communication and Coordination with Emergency Responders and Resources. EPP will be reviewed on 1/5/2023 with follow up on 1/11/2023. IV. QAPI Committee will be scheduled to review EPP on an annual and as needed basis. Procedure for Communication with Emergency Responders and Resources will be reviewed at annual review and as changes are identified.	01/11/2023
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d)			

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	155490	A. BUILDING -- B. WING	12/13/2022

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

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	EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.			

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	155490	A. BUILDING -- B. WING	12/13/2022

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

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	*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed reviewed and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 12/13/22 between 9:25 a.m. and 1:05 p.m., the EEP	E 0036	I. Current Training and Testing Policy will be reviewed and updated on 1/5/2023 and follow up completed on 1/11/2023. II. All residents and staff have been identified as having the potential to be affected. III. Corrective action will include current Training and Testing policy will be reviewed and	01/11/2023

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	12/13/2022

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	cover page did not have an annual update which was current. The last update to the EPP indicated on the cover page was 11/15/19 and no other date could be found to show EPP's Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator stated that when she opened the EPP she noticed that an annual review had not been done indicating the EPP was updated within the last year. This finding was acknowledged by the Administrator and Maintenance Director at the time discovery and again at the exit conference.		updated as necessary on 1/5/2023 and follow up completed on 1/11/2023. IV. QAPI Committee will be scheduled to review EPP on an annual and as needed basis. Training and Testing Policy will be reviewed at annual review and updated as necessary.	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is			

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	155490	A. BUILDING -- B. WING	12/13/2022

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AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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	not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility			

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	155490	A. BUILDING -- B. WING	12/13/2022

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

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	based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the			

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	155490	A. BUILDING -- B. WING	12/13/2022

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

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	emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual			

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	155490	A. BUILDING -- B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include,			

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	12/13/2022

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

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	but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility			

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	12/13/2022

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

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	based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is			

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	12/13/2022

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

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	led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group			

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	155490	A. BUILDING -- B. WING	12/13/2022

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

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	discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a			

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	155490	A. BUILDING -- B. WING	12/13/2022

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	narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop	E 0039	I. On December 26, 2022 the facility experienced a live event that triggered the ICS activation. This event will be counted as a facility-based event. II. All residents and staff have been identified as having the potential to be affected. III. Corrective action will include live exercises will be tentatively scheduled at QAPI Committee meetings and reviewed and adjusted as necessary for time frame availability. Once a date is determined a task will be added in the TELS system to track event. Live events will be recorded as facility-based or community-based dependent on the type of event. IV. QAPI Committee will monitor for completion of live exercises and live events to ensure that the 2 per year requirement is met.	01/11/2023

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	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 12/13/22 between 9:25 a.m. and 1:05 p.m., the facility was able to provide documentation of an exercise Elopement Drill on 10/7/22, however, was unable to provide documentation of a second exercise of choice to test the emergency preparedness plan. Based on interview at the time of record review, the Administrator agreed that a second exercise of choice was not conducted. This finding was acknowledged by the Administrator and Maintenance Director at the time discovery and again at the exit conference.			
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.			

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	155490	A. BUILDING -- B. WING	12/13/2022

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	§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security			

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	Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6,			

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	2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 12/13/22 between 9:25 a.m. and 1:05 p.m., the facility provided documentation for testing of the emergency generator, however could not provide documentation of a three year 4 hour test. This was confirmed by the Maintenance Director who stated he was unaware of the location for documentation relating to this requirement. This finding was acknowledged by the Administrator and Maintenance Director at the time discovery and again at the exit conference.	E 0041	I. A 4-hour load test will be performed. II. All residents have been identified as having the potential to be affected. III. Corrective action will include a 4-hour load test is scheduled to be performed on 1/4/2023. IV. Routine Maintenance work order will be added to the TELS system to perform a 4-hour load test every 36 months. The Maintenance Supervisor will report any findings to the Administrator and completion of scheduled maintenance will be monitored through the TELS system. Any overdue tasks will be addressed as identified.	01/11/2023
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: 12/13/22 Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750	K 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law.	

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	12/13/2022

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

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	At this Life Safety Code survey, Ambassador Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two-story facility with a partial basement consists of four attached buildings. Building 01 is a one-story building consisting of Rooms 101 through 120 and Rooms 1 through 8 in the two-story section of the west wing which has a partial basement. Building 02 is a one-story building consisting of rooms RH1 through RH18. 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 88 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 12/19/22		We are requesting a desk review for this survey.	

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	155490	A. BUILDING 01 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 1 of over 4 corridors or met an exception per 19.2.3.4(4). LSC 19.2.3.4(4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect 4 residents. Findings: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., a three-drawer cart without wheels was being stored in the corridor outside resident room RH12.	K 0232	I. Isolation bin outside room RH12 was removed and replaced with an isolation bin that was equipped with wheels. II. A walk through of the facility was completed to ensure no other corridor obstructions were present. No further obstructions were found. III. Corrective action will include Administrator/Designee will walk hallways randomly to ensure no prohibited corridor obstructions are present. Any findings will be corrected immediately. Education provided to staff to ensure awareness of requirement for items placed in corridors. IV. Maintenance Director/Administrator/Designee will continue to monitor corridors to ensure no prohibited corridor obstructions are present.	12/20/2022

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	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 4 of 9 exit discharge had a level walking surface or were free of obstructions. This deficient practice could affect 25 residents. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., the following exit discharge issues were observed: A) The East Exit sidewalk had 2 chairs sitting on the sidewalk obstructing the path. B) The 300 South Exit had a concrete landing which adjoined an elevated wooden ramp. Where the concrete pad and wooden ramp meet, there was a 5-6 inch gap creating a hole in the elevated ramp. C) The West Hall South Exit had railing which was falling and not secure. D) The West Hall North Exit had railing which was not secure and wobbly.	K 0271	I. The ramp of the 300 hall will be secured to the building both at the exit and the length of the ramp. The West Hall South Exit railing will be stabilized and secured with boards being replaced as necessary and posts adjusted. The post to the West Hall North Exit will be replaced and railing secured and stable. The chairs on the East Exit have been removed from the sidewalk. II. A walk through of the facility was completed to ensure no other exits were affected. No further issues were found. III. Corrective action will include Administrator/Designee educated East staff members that	01/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		chairs are prohibited from being placed on the sidewalk outside the East Exit. Repair and replacement of exit railings and ramp will be completed. IV. Inspection of Exit Ramps and railings will be added to the Monthly Routing Maintenance work order in TELS. Documentation and completion will be monitored by the Administrator through the TELS system and any overdue work orders will be addressed as discovered.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview; the facility failed to install exit signage outside the east exit in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious.	K 0293	I. A directional sign will be installed at the sidewalk of the East Exit directing individuals to the closest access to a public way. II. A walk through of the facility was completed to ensure no other exits were affected. No further issues were found.	01/11/2023

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	12/13/2022

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AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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	This deficient practice could affect 25 staff and residents exiting to the east. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., leading out of the East Exit and onto the exit discharge no signage was present to indicate which way to go on the sidewalk to most closely access the public way. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		III. Corrective action will include installation of directional exit signs at any exit where the egress path is not obvious. IV. Exit sign will be checked on a quarterly basis to ensure the sign is in good condition. A quarterly work order will be added in the TELS system and documentation, and completion of work order will be monitored by the Administrator/Maintenance Director and any overdue work orders will be addressed promptly.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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. Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's	K 0300	I. All battery-operated smoke detector batteries will be changed and recorded on battery change log. II. All residents with battery operated smoke detectors were identified as being affected. III. Corrective action will	01/11/2023

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	12/13/2022

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

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	published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 12/13/22 between 9:25 a.m. and 1:05 p.m., the itemized list of resident room battery operated smoke alarms showed testing for functionality but did not indicate if the alarms were cleaned annually or when the batteries had most recently been changed. The Maintenance Director stated the batteries had been changed but he was unsure of exactly when. This finding was acknowledged by the Administrator and Maintenance Director at the time discovery and again at the exit conference. 3.1-19(b)		include replacement of all batteries in battery-operated smoke detector with log recorded with the date of the change. IV. Battery change and log will be added to the TELS routine work order system. Completion and documentation will be monitored through the TELS system. Any overdue work orders will be addressed as identified.	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure 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			

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	155490	A. BUILDING 01 B. WING	12/13/2022

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	fire resistance rating, also check this box. Based on observation and interview, the facility failed to ensure the protection of 1 of 4 stairwells in accordance of 19.3.1. LSC 19.3.1.1 states where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. LSC 8.3.4.2 states the fire protection rating for opening protectives shall be in accordance with Table 8.3.4.2 except as otherwise permitted in 8.3.4.3 or 8.3.4.4. Table 8.3.4.2 requires fire door assemblies in vertical shafts, including stairways, to have a 1-hour fire resistance rating. LSC 8.3.4.3 states existing fire door assemblies having a minimum ¾-hour fire protection rating shall be permitted to continue to be used in vertical openings and exit enclosures in lieu of the minimum1-hour fire protection rating required in Table 8.3.4.2. This deficient practice could affect 8 residents. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., the area described as the "old house entry stair storage closet" was located directly under the staircase to the second floor in the West building and was being used to store paintings, boxes, small furniture and other combustible material. This was verified by maintenance director. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)	K 0311	I. Items will be removed from West stairwell. II. A walk through of the facility was completed to ensure no other storage items were placed in stairwells. No further issues were found. III. Corrective action will include signage hung on outside door to stairwell stating “No Storage”. Education was provided to staff regarding storage of items in stairwells. IV. Stairwell checks will be added to the weekly routine maintenance work order in the TELS system. Any items found will be removed as found. Administrator/Designee will monitor TELS system for work order completion and any overdue work orders will be addressed promptly.	01/11/2023

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	155490	A. BUILDING 01 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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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) Based on observation and interview, the facility failed to maintain the ceiling construction in in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 10 residents and staff. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., Sprinkler	K 0351	I. Escutcheon on the sprinkler in the North Nurses Station Medical room and in the Oxygen Transfilling Room will be replaced. The Therapy Area Linen closet was rearranged so that proper spacing between storage items and the sprinkler system was obtained. II. A walk through of the facility was completed to ensure no other sprinkler issues were present. No further issues were found.	01/11/2023

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	155490	A. BUILDING 01 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Heads in (1) the Medical Room on the North Nurses Station and (2) the Oxygen Transfilling Room were missing an escutcheon and did not completely cover the hole around the sprinkler. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 2. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in the Linen and Storage Closest in accordance with 19.3.5.1. NFPA 13, 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 up to 4 staff. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., The Therapy Area Linen Closet had storage stacked up to the ceiling and up against the sprinkler head. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present.		III. Corrective action will include escutcheon replacement. Education provided to therapy department about requirements for storage in relation to distance from sprinkler heads. IV. Sprinkler inspections will be completed by Koorsen Fire Protection as scheduled and any maintenance issue found during inspection will be addressed. Maintenance Director will perform periodic inspections of therapy storage closet to ensure compliance. Any identified issues will be corrected as found.	

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	155490	A. BUILDING 01 B. WING	12/13/2022

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

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K 0353 SS=C Bldg. 01	3.1-19(b) 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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special	K 0353	I. New spare sprinkler box ordered for proper storage of spare sprinkler heads. II. No other overcrowded sprinkler head boxes were identified. III. Corrective action will include spare sprinklers will be placed in each slot of spare sprinkler box along with special sprinkler wrench for proper storage. IV. Spare sprinkler head	01/11/2023

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	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., the facility had 2 spare sprinkler boxes which were overcrowded, containing more than the 6 slots can accommodate. Additionally, one spare sprinkler box was sitting on a ledge in the basement of the west building, containing 13 heads (only protected slots for 6) and the box was not mounted. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		boxes will be added as necessary so that no box holds more than the protected slots allow. Maintenance Director will inform Administrator if additional spare sprinkler boxes are needed.	
K 0355 SS=B Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 4 of 4 portable fire extinguishers in the maintenance area were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger	K 0355	I. Fire extinguisher in the maintenance basement was mounted to the wall in the basement. II. A walk through of the facility was completed and revealed no other improperly	12/20/2022

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	12/13/2022

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

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	intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect 8 staff in basement area. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., 4 ABC portable fire extinguishers in the basement maintenance area were sitting on the floor unsupported. The Maintenance Director stated that they were waiting for Koorsen to come and pick them up or recharge the extinguishers. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		stored fire extinguishers. III. Corrective action will include education provided to Maintenance Staff regarding the need for extinguishers to be stored in a proper location. All new extinguishers will be given to the Maintenance Director for proper installation and storage. IV. Monthly evaluation of Fire Extinguishers will be added to the routine maintenance work order in TELS. Administrator will monitor the completion of work orders through the TELS system.	
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			

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	155490	A. BUILDING 01 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	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 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.			
	1. Based on observation and interview, the facility failed to ensure 3 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 15 residents. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., the following corridor doors had holes which penetrated completely through the door:	K 0363	I. Adapter plates have been ordered for the ½ hole/gap through the door above the latching hardware in the service hall to the kitchen, the two ¼ inch holes and 2 inch hole in the clean utility closet on East, the ½ inch hole/gap to the housekeeping closet on West. These adapter plates will be installed when they arrive. After inspection of Room 201 it was	01/11/2023

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	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	A) A 1/2 inch hole/gap through the door above the latching hardware in the service hall door into the kitchen. B) Two 1/4 inch holes and 1 2 inch hole through the door in the Clean Utility Closet on the Vent Unit. C) A ½ hole/gap around the latching hardware in the corridor door to the housekeeping closet on the West Hall. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 2. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., the corridor door to Resident Room 201 failed to close and latch positively into the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present.		found that the door handle required replacement. Replacement was completed and door to Room 201 closed properly once replacement was completed. II. A walk through of the facility was completed and revealed no other door gaps or improper latching mechanisms were identified. III. Corrective action will include replacement of non working latching mechanisms and repair of any holes in smoke barriers to resist the passage of smoke. IV. Quarterly latching mechanism inspection will be added to the routine maintenance work order in TELS. Completion of work orders will be monitored by the Administrator/Designee and any overdue work orders will be addressed as identified.	

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	12/13/2022

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

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	3.1-19(b)			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 15 residents. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., the set of barrier doors into the Ventilator unit did not close completely and latch. Based on interview during the time of observations, the Maintenance Director acknowledged these barrier doors did not	K 0374	I. Fire door hardware was adjusted to ensure proper closure when activated. II. A walk through of the facility was completed and revealed no other issues with fire door closure. III. Corrective action will include education provided to staff to not adjust hardware on any fire door. Director of Maintenance shall be responsible for any needed adjustments. IV. Inspection of Fire Door hardware will be added to the Monthly routine maintenance work	12/20/2022

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	12/13/2022

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

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	close completely and latch. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		order in TELS system. Administrator will monitor completion of work orders through TELS.	
K 0511 SS=E 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 1. Based on observation and interview, the facility failed to ensure 1 of 1 ground fault circuit interrupter (GFCI) in the pantry was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect 20 residents and staff. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., when the GFCI electric receptacle at the dining room sink was tested with a GFCI tester the GFCI receptacle failed to trip and did not break the electrical circuit and indicated a possible open ground. Based on interview at the time of observation, the	K 0511	I. Ground wire in the GFCI receptacle in the North Dining Room has been repaired. Retest of receptacle indicated no further issue with GFCI. Vent cover has been ordered for the Medical Room at the North Nurses station and will be installed when it arrives, junction box cover was installed in the West basement near the old oil tanks, junction box cover was installed in the West basement near the water heater, cover was replaced to the 125-amp panel in the West basement, junction box cover was replaced in the West dining room, junction box cover was replaced in the ceiling above room RH20 and the outlet cover was replaced in the South Shower room.	01/11/2023

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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	Maintenance Director agreed the GFCI electric receptacle did not work properly when tested and the tester was indicating a "open ground" wiring issue. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 2. Based on observation, the facility failed to ensure 6 of 6 electrical junction boxes were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff and 15 and staff. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., the following electrical boxes had exposed wires: A) The Medical Room in the North Nurses Station. B) Basement of the West Building near the old oil tanks C) Basement of the West Building near the water heater. D) Basement of the West Building the 125-amp panel was missing a cover. E) In the West building Dining room a junction box was missing a cover.		II. A walk through of the facility was completed and revealed no other utility issues. III. Corrective action will include replacement of all missing covers and continued GFCI receptacle checks. IV. Yearly receptacle testing will be entered into the TELS system routine maintenance work orders. Work orders will be monitored by the Administrator/Designee and any overdue work orders will be addressed as identified.	

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	F) Above the ceiling near RH20 a Junction Box cover was missing. G) In the Memory Care unit, shower closet, an outlet was missing a cover. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)			
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 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			

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	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) 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 building occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director on 12/13/22 between 9:25 a.m. and 1:05 p.m., the facility provided documentation for testing of the emergency generator, however could not provide documentation of a three year 4 hour test. This was confirmed by the Maintenance Director who stated he was unaware of the location for documentation relating to this requirement.	K 0918	I. A 4-hour load test will be performed. II. All residents have been identified as having the potential to be affected. III. Corrective action will include a 4-hour load test is scheduled to be performed on 1/4/2023. IV. Routine Maintenance work order will be added to the TELS system to perform a 4-hour load test every 36 months. The Maintenance Supervisor will report any findings to the Administrator and completion of scheduled maintenance will be monitored through the TELS system. Any overdue tasks will be addressed as identified.	01/11/2023

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	This finding was acknowledged by the Administrator and Maintenance Director at the time discovery and again at the exit conference. 3.1-19(b)			
K 0919 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Other Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, 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 10 (NFPA 99) Based on observation, record review, and interview, the facility failed to ensure policies and training were established to operate appliances in a safe manor in 1 of 1 resident care location. NFPA 99, Health Care Facilities Code 2012 Edition, Section 10.5.2.7 states policies shall be established for the control of appliances not supplied by the facility. This deficient practice could affect 2 residents. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., in room RH 12, a Crock Pot was on the lower shelf in the resident room. The plug had a zip tie through it which would require removal prior to use and could easily be removed. The Administrator stated that the appliance was not provided by the facility. No documentation was provided showing policies had been established for the control of appliances not supplied by the facility. The	K 0919	I. Crockpot was removed from Room RH12. II. A walk through of the facility was completed and revealed no other crockpots in any other resident rooms. III. Corrective action will include education provided to family of Room RH12 and staff that crockpot cannot be stored in resident room. Admissions personnel will inform residents and family on admission in reference to what items are allowed to be in resident rooms. Staff have been educated that if any items are found in resident rooms to notify charge nurse so items can be removed. IV. Staff have been	12/20/2022

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	Maintenance Director stated that the facility was unaware of the crock pot. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		educated that if any items are found in resident rooms to notify charge nurse so items can be removed. Random audits of patient rooms will be conducted periodically to ensure any improper items are located and removed.	
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 1. Based on observation and interview, the facility failed to ensure power strips in the therapy area	K 0920	I. Dishwasher in the East Soiled utility room was	12/28/2022

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	were of UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet 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 feet 6 inches above the floor. This deficient practice affects 5 staff and residents. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., 1 of 2 the power strips being used in the therapy area lacked a UL rating of 1363A or 60601-1 label. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., in the Soiled Utility room on the East hall a dishwasher was being powered by an extension cord made of Romex and concealed under the baseboard. The		relocated and original power cord was reinstalled. Dishwasher is now plugged into wall outlet with proper cord. The power strip located in the therapy department was removed and replaced with an approved computer battery back up power surge box. II. A walk through of the facility was completed and revealed no other issues with electrical cords. III. Corrective action will include education of therapy staff in the use of proper power strips and electrical cords and need for approval of Maintenance Director before any changes can be made to power cords or strips. IV. All new electrical cords and power strips will be inspected by Maintenance Director for proper use and approval before installation.	

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	cord extended behind the counter and up and terminated into a GFCI outlet on the wall. Based on interview at the time of observation, the Maintenance Director acknowledged the homemade extension cord and was shocked at how it was wired. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)			
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 20 residents in one smoke	K 0927	I. Ventilation fan in O2 room was repaired for proper usage. II. A walk through of the facility was completed and revealed no other issues with ventilation fans. III. Corrective action will	01/11/2023

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	compartment. Findings include: Based on a facility tour and interview with the Administrator and the Maintenance Director on 12/13/22 between 1:05 p.m. and 4:10 p.m., the oxygen storage/transfer room contained large liquid oxygen tanks. The mechanical ventilation was not working and the vent was missing a cover. Based on interview at the time of observation, the Maintenance Director stated that someone might have been working on it, but clearly the fan blades were not working. This finding was acknowledged by the Maintenance Director at the time discovery and again at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		include exhaust fans being added to the monthly routine maintenance work order in TELS system. IV. Documentation of completion will be monitored through the TELS system and any overdue items will be addressed as discovered.	