| 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 | 09/25/2018 |

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

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 09/25/18<br><br>Facility Number: 000456<br>Provider Number: 155490<br>AIM Number: 100288750<br><br>At this Emergency Preparedness survey, Ambassador Healthcare was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has 137 certified beds. At the time of the survey, the census was 126.<br><br>Quality Review completed on 10/01/18 - DA<br><br>The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: | E 0000 | | |
| E 0026<br>SS=C<br>Bldg. -- | Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all occupants. | E 0026 | I. The Emergency Preparedness Policy and Procedure Manual has been updated to include the 1135 Waiver Policy as of 10/5/2018.<br><br>II. All residents currently residing in the facility are identified as having had the | 10/25/2018 |

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

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| | Findings include:<br><br>Based on record review with the Maintenance Supervisor on 09/25/18 at 12:28 p.m., a policy and procedure for the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was not available for review. Based on interview at the time of record review then again at the exit conference, the Maintenance Supervisor confirmed he was unaware of the regulation and that no policy and procedure was available for review. | | potential to be affected.<br><br>III. Management will continue to review polices and procedures relating to emergency preparedness. We also have a close relationship with the local Emergency Management Agency and will continue to seek their guidance in updates. Management will also continue to attend seminars and/or training sessions relating to emergency preparedness policies and procedures.<br><br>IV. Quarterly the Administrator will review the Emergency Preparedness Policy and Procedure to the QAPI committee and educate of the same as required but not less than annually. QAPI and the Administrator will monitor for additional mandates.<br><br>V. Completion by October 25, 2018 | |
| E 0034 SS=C Bldg. -- | 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 | E 0034 | I. The facility's communication plan has been updated to include information regarding occupancy, needs, and its ability to provide assistance to the authority having jurisdiction or Incident Command Center or designee. | 10/25/2018 |

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| | deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Maintenance Supervisor on 09/25/18 at 12:37 p.m., a communication plan that included a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the Authority Having Jurisdiction (AHJ) or the Incident Command Center (ICC), or designee in accordance with 42 CFR 483.73(c)(7) was not available for review. Based on interview at the time of record review then again at the exit conference, the Maintenance Supervisor confirmed that the communication plan did not include the aforementioned occupancy, needs, and ability to provide assistance to the AHJ, ICC, or designee. | | II. All residents currently residing in the facility are identified as having had the potential to be affected.<br><br>III. Management will continue to review policies and procedures relating to emergency preparedness. We also have a close relationship with the local Emergency Management Agency and will continue to seek their guidance in updates. Management will also continue to attend seminars and/or training sessions relating to emergency preparedness policies and procedures.<br><br>IV. Quarterly the Administrator will submit updates of the Emergency Preparedness Policy and Procedure to the QAPI committee and educate of the same. QAPI and the Administrator will monitor for additional mandates.<br><br>V. Completion by October 25, 2018 | |
| E 0035 SS=C Bldg. -- | Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with | E 0035 | I. As of 10/12/2018 all residents and/or resident representatives have been notified of the Emergency Preparedness Communication Plan via mail and | 10/25/2018 |

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| K 0000 | residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Maintenance Supervisor on 09/25/18 at 12:34 p.m., the emergency preparedness communication plan failed to include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). Based on interview at the time of record review, the Maintenance Supervisor confirmed they have not created a method for sharing information from the emergency plan. | | written communication. Additionally, the current Communication Plan Policy and Procedure was available in the facility at the time of the survey has been reviewed and updated.<br><br>II. All residents currently residing in the facility are identified as having had the potential to be affected.<br><br>III. Management will continue to review policies and procedures relating to emergency preparedness. We also have a close relationship with the local Emergency Management Agency and will continue to seek their guidance in updates. Management will also continue to attend seminars and/or training sessions relating to emergency preparedness policies and procedures.<br><br>IV. Quarterly the Administrator will submit updates of the Emergency Preparedness Policy and Procedure to the QAPI committee and educate of the same. QAPI and the Administrator will monitor for additional mandates.<br><br>V. Completion by October 25, 2018 | |

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| Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 09/25/18<br><br>Facility Number: 000456<br>Provider Number: 155490<br>AIM Number: 100288750<br><br>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.<br><br>This two story facility with a partial basement was determined to be of Type V (111) construction and fully sprinkled except the second floor conference room closet. The facility has a fire alarm system with smoke detection on all levels including the partial basement, the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 126 at the time of this visit.<br><br>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the detached storage building and the detached walk in cooler and walk in freezer.<br><br>Quality Review completed on 10/01/18 - DA | K 0000 | | |

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| K 0100 SS=E Bldg. 01 | NFPA 101<br>General Requirements - Other<br>General Requirements - Other<br>List in the REMARKS section any LSC Section 18.1 and 19.1 General 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.<br>Based on observation and interview, the facility failed to maintain latching hardware on 1 of 2 East Unit smoke barrier doors per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff and up to 21 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 2:45 p.m., the smoke barrier doors near resident room 202 contained latching hardware. When tested, one of the smoke barrier doors failed to latch. Based on interview at the time of observation, the Maintenance Supervisor confirmed one of the two smoke barriers doors failed to latch.<br><br>3.1-19(b) | K 0100 | I. As of 10/9/2018 the latching hardware on South 202 has been repaired.<br><br>II. The residents residing on the South 200 hall are identified as having had the potential to be affected.<br><br>III. Management has reviewed and updated the Monthly Preventative Maintenance Log. Monthly assignments will be assigned individually to check, and repair smoke barriers as needed.<br><br>IV. The Maintenance Supervisor will be responsible to monitor each smoke barrier each month. A monthly meeting will be scheduled with the Administrator to discuss and report any concerns relating to smoke barriers. Quarterly the Maintenance Supervisor will report any findings or concerns to the QAPI committee with interventions for corrections implemented. | 10/25/2018 |

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| | | | V. Completion October 25, 2018 | |
| K 0222 SS=E Bldg. 01 | NFPA 101<br>Egress Doors<br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. | | | |

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| | 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4 | | | |
| | 1. Based on observation, record review, and interview, the facility failed to ensure the facility failed to ensure 4 of 6 exterior exits had a code posted for locking devices that did not require special knowledge to open. LSC 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. This deficient practice could | K 0222 | I. As of 10/9/2018, all doors within the facility with delayed egress locking systems have codes posted by the number pads. Each posting is a one (1) inch post and clearly states number codes and symbols. The latch on the wooden gate on South Unit has been removed. The latch on the West nurse's station bathroom door has been removed. | 10/25/2018 |

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| | affect staff and up to 39 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 between 12:50 p.m. and 5:06 p.m., the north halls and 600 Halls exit doors were held in the locked position with a magnetic hold down device. Furthermore, the exit doors were equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A sign was near each keypad that read "*V V V *." Based on an interview at the time of each observation, the Maintenance Supervisor confirmed the V's were supposed to be roman numerical number 5.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 5 South Unit exits were readily accessible for occupants. LSC 7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. This deficient practice could affect staff and up to 15 residents currently in the area.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 10:35 a.m., the South Unit Dining room exited into a gated courtyard. The courtyard exit gate contained two latching devices on the non-egress side of the door. An eye hook latch system and a pole inserted into the cement. Based on interview at the time of the observation, the Maintenance Supervisor confirmed the door contained two latching devices and was only operable from the | | II. All residents residing in the facility have been identified as affected.<br><br>III. The Monthly Preventive Maintenance Log has been updated to include checking for accurate code postings and impediments to egress.<br><br>IV. Maintenance Supervisor will meet with the Administrator monthly to review PM Log to manage and monitor corrections or concerns regarding egress.<br><br>V. Completed October 25, 2018 | |

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| | non-egress side.<br><br>3.1-19(b) | | | |
| K 0232<br>SS=E<br>Bldg. 01 | NFPA 101<br>Aisle, Corridor, or Ramp Width<br>Aisle, Corridor or Ramp Width<br>2012 EXISTING<br>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.<br>19.2.3.4, 19.2.3.5<br>Based on observation, the facility failed to meet 1 of 8 corridors clear width requirement exception per 19.2.3.4(5). LSC 19.2.3.4(5) requires where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture. LSC 19.2.3.4(5)(a) the fixed furniture is securely attached to the floor or to the wall. This deficient practice could affect staff and up to 24 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 1:55 p.m., a stool was located in the corridor outside of resident room 104. When tested, the stool was able to be moved around the corridor. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the stool was not secured to the floor or wall.<br><br>3.1-19(b) | K 0232 | I. The stools located at Room 104 and RH 7 have been removed and are no longer accessible to impede the requirements.<br><br>II. Residents residing on North Unit and Vent Unit are identified as having had the potential to be affected.<br><br>III. The inspection of corridors is now on the Monthly Preventative Maintenance Log. The Administrator held a maintenance department meeting on 10/4/2018 to inform and instruct on issues relating to Life Safety and proper monitoring and maintenance of the facility.<br><br>IV. The Maintenance Supervisor or designee is responsible to monitor corridors for clearance. QAPI will review | 10/25/2018 |

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| | | | quarterly for compliance.<br><br>V. Completion October 25, 2018 | |
| K 0300 SS=F Bldg. 01 | NFPA 101<br>Protection - Other<br>Protection - Other<br>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.<br>Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance for 100 of 100 battery operated smoke alarms in resident rooms was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Maintenance Supervisor on 09/25/18 at 10:40 a.m., the battery operated smoke alarm maintenance documentation indicated the last time batteries were replaced was 06/17/17. Based on interview at the time of record review, the Maintenance Supervisor confirmed the facility's policy is to change the batteries with the semiannual time daylight changes.<br><br>3.1-19(b) | K 0300 | I. All batteries will be changed and documented on the Battery-Operated Smoke Detector Maintenance Log. All batteries will remain on the fall/spring time change schedule. The maintenance assistant confirms the batteries were changed on the Spring 2018 cycle, as logged. However, the individual failed to place date in proper column.<br><br>II. All residents residing in rooms or areas where battery operated smoke detectors are located have had the potential to be affected.<br><br>III. Maintenance Supervisor will check the Battery-Operated Smoke Detector Maintenance Log two (2) times yearly.<br><br>IV. Administrator and | 10/25/2018 |

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|---|---|---|---|---|
| | | | Maintenance Supervisor will monitor for completion and accuracy of documentation.<br><br>V. Completed October 25, 2018. | |
| K 0341<br>SS=E<br>Bldg. 01 | NFPA 101<br>Fire Alarm System - Installation<br>Fire Alarm System - Installation<br>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 17.7.3.1.2 requires the location and spacing requirements shall be based on six factors. (2) Ceiling height. (5) Compartment ventilation. NFPA 72 17.7.3.2.1 spot-type smoke detectors shall be located on the ceiling, or, if on a sidewall, between the ceiling and 12 inches down from the ceiling to the top of the detector. This deficient practice could affect staff and up to 44 residents at the East Unit Dining room. | K 0341 | I. The contracted alarm maintenance company assessed for installation of additional smoke detectors for the South Dining Room on 10/10/18. We will insure the proper 12-inch placement on ceiling.<br><br>II. All residents residing on the South Unit are identified as having the potential to be affected.<br><br>III. Maintenance will inspect all cathedral ceilings for | 10/25/2018 |

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| AMBASSADOR HEALTHCARE | 705 E MAIN ST<br>CENTERVILLE, IN 47330 |

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| | Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 2:42 p.m., the South Unit Dining room contained two smoke detectors fifteen feet from the peak of the ceiling. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the smoke detector location and provided the measurement.<br><br>3.1-19(b) | | proper placement. Alarm maintenance company has evaluated needs for smoke detectors on 10/10/18. The company will be authorized to make additions as necessary by 10/25/18.<br><br>IV. Maintenance Supervisor will monitor placement of smoke detectors for compliance.<br><br>V. Completion October 25, 2018 | |
| K 0351<br>SS=C<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Installation<br>Spinkler System - Installation<br>2012 EXISTING<br>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.<br>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.<br>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.<br>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) | | | |

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| | Based on observation and interview, the facility failed to ensure a 1 of 1 complete automatic sprinkler system was installed in accordance with 19.3.5.1. NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, Section 9.1.1.7, Support of Non-System Components, requires sprinkler piping or hangers shall not be used to support non-system components. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on observations with the Maintenance Supervisor on 09/25/18 at 12:58 p.m., three coats were suspended from the sprinkler pipe in the Laundry room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged and removed the coat hangers from the sprinkler pipe.<br><br>3.1-19(b) | K 0351 | I. On 10/1/2018 a staff meeting was held with the laundry department to counsel employees on appropriate placement of hangers and slings. The department acknowledged understanding by signature.<br><br>II. Residents residing on South 300 hall are identified as having the potential to be affected.<br><br>III. Maintenance will make available a designated rack to be used for “hang to dry” articles.<br><br>IV. Maintenance and Laundry Supervisor will monitor to insure nothing is placed on sprinkler pipe.<br><br>V. Completion October 25, 2018 | 10/25/2018 |
| K 0353<br>SS=C<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>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.<br>Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test | | | |

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| | c) Water system supply source<br><br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Maintenance Supervisor on 09/25/18 between 10:12 a.m. and 11:31 a.m., the sprinkler system was inspected quarterly by a contracted vender. No documentation was available for the monthly control valves and weekly dry system gauge inspections. Based on interview at the time of record review, the Maintenance Supervisor stated the weekly and monthly inspections were being done but no documentation is available to review.<br><br>3.1-19(b) | K 0353 | I. The monthly control valve inspection and weekly dry system gauge has been completed. The ceiling tiles have been replaced and secured as of 9/26/18.<br><br>II. All residents residing in the facility are affected as having had the potential to be affected.<br><br>III. Weekly visual inspections will be done by Maintenance Supervisor. This inspection will be documented on the Weekly Control Valve Inspection Log. Ceiling inspections will be documented on the Weekly PM Log.<br><br>IV. Maintenance Supervisor must submit logs quarterly to QAPI committee for review.<br><br>V. Completion October 25, 2018 | 10/25/2018 |
| K 0354<br>SS=C<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Out of Service<br>Sprinkler System - Out of Service<br>Where the sprinkler system is impaired, the | | | |

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| | extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service.<br>18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)<br>Based on record review and interview, the facility failed to provide a 1 of 1 written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Maintenance Supervisor on 09/25/18 at 11:20 a.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the insurance company. Based on an interview record review, the Maintenance Supervisor acknowledged fire watch policy failed to include contact information for contacting the insurance company. | K 0354 | I. The fire watch policy and procedure has been updated and completed with the property insurance information included with the name and phone number.<br><br>II. All residents residing in the facility are identified as having had the potential to be affected.<br><br>III. Management will continue to review policies and procedures relating to fire watch. Management will also continue to attend seminars and/or training sessions related to emergency response policies and procedures and updates. Facility will continue annual reviews due in November 2018.<br><br>IV. Emergency Response policies and procedures will be reviewed quarterly by the | 10/25/2018 |

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| | 3.1-19(b) | | QAPI committee for revisions and updates.<br><br>V. Completion October 25, 2018 | |
| K 0361 SS=E Bldg. 01 | NFPA 101<br>Corridors - Areas Open to Corridor<br>Corridors - Areas Open to Corridor<br>Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1.<br>18.3.6.1, 19.3.6.1<br>Based on observation and interview, the facility failed to ensure 2 of 8 corridors was separated from the corridors by a partition capable of resisting the passage of smoke in accordance with 19.3.6.1. This deficient practice could affect staff and up to 45 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 2:26 p.m. then again at 2:45 p.m., the corridor near resident room 116 had a two inch penetration. Then again, the corridor near resident room 210 had a two and a half inch penetration. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged the damaged drywall and provided the measurements.<br><br>3.1-19(b) | K 0361 | I. The penetrations located at Room 116 and Room 210 have been repaired.<br><br>II. The residents located on the North Unit and South 200 hall are identified as having had the potential to be affected.<br><br>III. Each month maintenance will inspect all corridor walls for any penetrations. The result of inspections will be placed on the Preventative Maintenance Log. Repairs are expected to be made immediately.<br><br>IV. The Maintenance Supervisor will monitor for completion and review with the Administrator monthly. Report on repairs and any interventions needed will be discussed at | 10/25/2018 |

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| | | | quarterly QAPI meeting.<br><br>V. Completion October 25, 2018 | |
| K 0363<br>SS=E<br>Bldg. 01 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that 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 | | | |

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| | resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>1) Based on observation and interview, the facility failed to maintain protection of corridor doors in 2 of 8 corridors in accordance of 19.3.6.3. This deficient practice could affect staff and at least 39 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 1:38 p.m. then again at 2:24 p.m., resident room 112 had a heavy figurine impeding the door from closing. Then again, resident room 122 had a large flower vase impeding the door from closing. Based on interview at the time of each observation, the Maintenance Supervisor confirmed the doors were impeded from fully closing and latching.<br><br>3.1-19(b)<br><br>2) Based on observation and interview, the facility failed to ensure 1 of 1 Dietitian room door was not impeded from closing. This deficient practice could affect staff and up to 15 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 1:59 p.m., the Dietitian room door was held open with a rubber belt which impeded the door from closing. Based on interview at the time of observation, the | K 0363 | I. The figurine in Room 112 and vase in Room 122 have been removed. The rubber belt was removed immediately. All items removed upon discovery.<br><br>II. All residents on North Unit and 600 hall are identified as having had the potential to be affected.<br>III. An all staff in-service will be held on October 15th to educate staff regarding Life Safety Code topics.<br><br>IV. Department heads, Maintenance Supervisor, and Administrator will monitor all hallways.<br><br>V. Completion October 25,2018 | 10/25/2018 |

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| | Maintenance Supervisor confirmed and removed the rubber belt.<br><br>3.1-19(b) | | | |
| K 0372 SS=E Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 8 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff and at least 60 residents.<br><br>Findings include:<br><br>Based on observations with the Maintenance Supervisor on 09/25/18 between 3:58 p.m. and 4:55 p.m., the following was discovered:<br>a) a half inch gap around ducts in the resident room 117 attic smoke barrier | K 0372 | I. The gaps in the smoke barriers located at rooms 117, 121, and 202 have been repaired and sealed with fire caulk. The ½ inch gap around the sprinkler pipe and wires have also been sealed.<br><br>II. All residents residing on the North Unit, South 200 hall, and East Unit are identified as having had the potential to be affected.<br><br>III. If any ceiling conduit or piping installations are made, the maintenance department will inspect after installation to insure | 10/25/2018 |

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| | b) a half inch gap around wires in the opposite side of the resident room 117 attic smoke barrier. Additionally, a three eighths inch gap around two separate HVAC ducts<br>c) a one and three eighths inch gap around wiring in the resident room 121 attic smoke barrier<br>d) a half inch gap around wires in the resident room 202 attic smoke barrier. Additionally in the attic smoke barrier, a half inch gap around wires<br>Based on interview at the time of each observation, the Maintenance Supervisor acknowledged cell phone photos taken of the penetrations and provided the estimated measurements.<br><br>3.1-19(b) | | wiring, etc. are sealed properly to prevent penetrations. The inspection will be logged on the Monthly PM Log.<br><br>IV. Maintenance department will monitor by performing a visual inspection monthly. Any needed interventions will be reported to the Administrator.<br><br>V. Completion October 25, 2018 | |
| K 0374 SS=E Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>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.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would self-close. This deficient practice could affect staff only. | K 0374 | I. As of 9/26/18 the door was repaired, self closes and latches securely in the frame.<br><br>II. This door is | 10/25/2018 |

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| | Findings include:<br><br>Based on record review with the Maintenance Supervisor on 09/25/18 at 12:54 p.m., one of the basement smoke barrier double doors caught on the floor and failed to fully closed. Additionally, one of the doors contained an astragal but no coordinating device was installed. Based on interview at the time of observation, the Maintenance Supervisor confirmed that a gap between the door and the frame was present.<br><br>3.1-19(b) | | accessible to the laundry department. The residents on South 300 Unit are identified as having had the potential to be affected.<br><br>III. All smoke barriers are scheduled on the Monthly Preventative Maintenance Log for inspection and repair as necessary.<br><br>IV. Maintenance department will monitor by doing a visual inspection monthly. Any needed interventions will be reported to the Administrator.<br><br>V. Completion October 25, 2018 | |
| K 0511<br>SS=D<br>Bldg. 01 | NFPA 101<br>Utilities - Gas and Electric<br>Utilities - Gas and Electric<br>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.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br>Based on observation and interview, the facility failed to ensure electrical outlets were protected in 1 of 1 Basement Classroom, 1 of 1 Medical Records office, and 1 of 1 Activities Storage room in according to 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This | K 0511 | I. The receptacle faceplates in Medical Records, Activity closet, and basement Classroom have been replaced.<br><br>II. Residents residing on South 300 hall are identified as having had the potential to be affected. | 10/25/2018 |

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| | deficient practice could staff only.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 1:05 p.m. then again at 1:08 p.m., the following was discovered:<br>a) one of the outlets in the Basement Classroom was missing an outlet cover<br>b) one of the outlets in the Medical records office was missing an outlet cover<br>c) one of the outlets in the Activities Storage room was missing an outlet cover<br>Based on interview at the time of each observation, the Maintenance Supervisor acknowledged each missing outlet cover.<br><br>3.1-19(b) | | III. Maintenance will inspect all receptacle faceplates monthly and replace as needed. This measure will be placed on the Monthly Preventative Maintenance Log.<br><br>IV. Maintenance Supervisor will review with the Administrator monthly for intervention and compliance.<br><br>V. Completion October 25, 2018 | |
| K 0712<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Drills<br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>19.7.1.4 through 19.7.1.7<br>Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. | K 0712 | I. On 10/1/18 a second shift fire drill was completed at 3:00 PM. On 10/13/18 a third shift fire drill will be completed. | 10/25/2018 |

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| | Findings include:<br><br>Based on record review of the "Fire Drill Report" forms with the Maintenance Supervisor on 09/25/18 at 10:58 a.m., there was no documentation for a second shift fire drill in the fourth quarter of 2017. Additionally, there no was no documentation for a third shift fire drill in the first quarter of 2018. Based on interview at the time of record review, the Maintenance Supervisor were unable to provide further documentation.<br><br>3.1-19(b)<br>3.1-51(c) | | II. All residents residing in the facility have been identified as having had the potential to be affected.<br><br>III. Fire drills have been separated from all other documentation. A fire drill binder has been created with a calendar for one year with dates, times, and shifts scheduled.<br><br>IV. Maintenance Supervisor will meet with the Administrator monthly to review completion of monthly drills.<br><br>V. Completion October 25, 2018 | |
| K 0753<br>SS=E<br>Bldg. 01 | NFPA 101<br>Combustible Decorations<br>Combustible Decorations<br>Combustible decorations shall be prohibited unless one of the following is met:<br>o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product.<br>o Decorations meet NFPA 701.<br>o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.<br>o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).<br>o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.<br>19.7.5.6 | | | |

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| | Based on observation and interview, the facility failed to ensure 1 of 1 candle was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect staff and up to 15 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 2:24 p.m., resident room 122 contained a candle with a wick. Based on interview at the time of observation, the Maintenance Supervisor confirmed a wick was in the candle.<br><br>3.1-19(b) | K 0753 | I. After further inspection of the “candle” in Room 122, it was discovered that it was a LED, battery powered light. See photo of light.<br><br>II. No residents are identified as having been affected.<br><br>III. All resident rooms will be inspected for candles. Upon admission residents and/or resident representatives will be notified that any open flame is not permitted in the facility. Staff will be reminded to monitor rooms during the in-service on (10/15/18) for candles.<br><br>IV. All staff will be requested to monitor and report any non-compliance to Social Services.<br><br>V. Completion October 25, 2018 | 10/25/2018 |
| K 0918<br>SS=F<br>Bldg. 01 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br>Electrical Systems - Essential Electric System Maintenance and Testing<br>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 | | | |

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| | NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 2 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having | K 0918 | I. Each Monday the generator is exercised for .5 hours from approximately 08:25 AM until 08:55 AM. The following times have been logged since survey:<br>10/1/18- hour meter at 530.1<br>10/8/18- hour meter at 530.6.<br><br>II. All residents residing in the facility are identified as having had the potential to be affected.<br><br>III. The contracted generator maintenance company | 10/25/2018 |

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| | jurisdiction. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Maintenance Supervisor on 09/25/18 at 10:18 a.m., documentation for March and April of 2018 indicated the generator was run for .4 hours. Based on an interview at the time of record review, the Maintenance Supervisor acknowledged and confirmed the generator was run for less than 30 minutes for two months.<br><br>3.1-19(b) | | will continue to service and maintenance the generator every 6 months. On 10/11/18 the company serviced the generator and evaluated its weekly 30-minute run and found it to be accurate.<br><br>IV. Maintenance Supervisor will check and log generator times for each Monday. Logs will be reviewed at quarterly QAPI meetings. Interventions will be completed if any discrepancies in the weekly inspection.<br><br>V. Completion October 25, 2018 | |
| K 0920 SS=E Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Electrical Equipment - Power Cords and Extension Cords<br>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 | | | |

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| | 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<br>1. Based on observation, record review, and interview, the facility failed to install 1 of 1 power strip according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 110.3(B) Installation and Use, states listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. This deficient practice affects staff and up to 15 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 2:06 p.m., a power strip was powering an oxygen concentrator, a nebulizer, and two separate cell phone chargers in resident room 129. Based on interview at the time of observation, the Maintenance Supervisor confirmed patient care and non-patient care related items were being powered by a medical grade power strip.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure 6 of 6 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, | K 0920 | I. Maintenance assistants have removed non-medical electrical equipment from Room 129 power strip. The Laundry microwave was plugged directly to the wall outlet and surge protector removed. The surge protector was removed from HR and the refrigerator was plugged directly into the wall. The microwave in Room 134 was plugged directly to wall outlet. The refrigerator on East nurse's station is plugged directly to wall and surge protector removed. The surge protector in Telecom Room has been removed. After further inspection of RH4 no coffee pot or refrigerator are present in residents' room. Both residents are ventilator dependent and totally dependent on staff for care.<br><br>II. All residents residing in the facility are identified as having had the potential to be affected.<br><br>III. An in-service will be held on 10/15/18 to inform staff regarding hospital grade surge protector use. The maintenance department will check every | 10/25/2018 |

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| | flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 13 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 between 1:00 p.m. and 4:33 p.m., the following was discovered:<br>a) a surge protector was powering a microwave in the Laundry room<br>b) a surge protector was powering a refrigerator in the Human Resources office<br>c) a surge protector was powering a microwave in resident room 134<br>d) a surge protector was powering a refrigerator at the East Nursing station<br>e) a surge protector was powering a surge protector powering a telecommunication equipment in the Telecom room<br>Based on interview at the time of each observation, the Maintenance Supervisor acknowledged and attempted to correct each surge protector.<br><br>3.1-19(b) | | resident room for proper compliant use and remedy as needed.<br><br>IV. Maintenance department will monitor by visual inspection monthly.<br><br>V. Completion October 25, 2018 | |
| K 0927<br>SS=D<br>Bldg. 01 | NFPA 101<br>Gas Equipment - Transfilling Cylinders<br>Gas Equipment - Transfilling Cylinders<br>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 | | | |

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| | liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99).<br>11.5.2.2 (NFPA 99)<br>Based on observation and interview, the facility failed to protect oxygen cylinders in the 1 of 1 oxygen transfill room. 2012 NFPA 99, Health Care Facilities Code, 11.6.2.3(11) requires freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 4:03 p.m., oxygen transfill room had ten oxygen cylinders that was freestanding on the floor. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the unprotected cylinders.<br><br>3.1-19(b) | K 0927 | I. Eight cylinders were counted as free standing in the oxygen room. These cylinders have been returned to oxygen company, as they were not in use. Currently sixteen (16) tanks are secured in a stationary cart. Liquid tanks are free standing and are behind a locked door.<br><br>II. All residents residing on the North Unit are identified as having had the potential to be affected.<br><br>III. The Charge Nurse and Respiratory Manager will evaluate oxygen needs and insure proper security of all oxygen cylinders and tanks.<br><br>IV. The Charge Nurse and Respiratory Manager will monitor security of all oxygen tanks and take corrective action if needed. Charge Nurse and/or Respiratory will report to ADON monthly any issues related to oxygen storage.<br><br>V. Completion October 25, 2018 | 10/25/2018 |
| K 0000<br><br>Bldg. 02 | | | | |

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| | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 09/25/18<br><br>Facility Number: 000456<br>Provider Number: 155490<br>AIM Number: 100288750<br><br>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.<br><br>This two story facility with a partial basement was determined to be of Type V (111) construction and fully sprinkled except the second floor conference room closet. The facility has a fire alarm system with smoke detection on all levels including the partial basement, the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 126 at the time of this visit.<br><br>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the detached storage building and the detached walk in cooler and walk in freezer.<br><br>Quality Review completed on 10/01/18 - DA | K 0000 | | |

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| K 0211 SS=E Bldg. 02 | NFPA 101<br>Means of Egress - General<br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br>18.2.1, 19.2.1, 7.1.10.1<br>Based on observation and interview, the facility failed to maintain 1 of 2 East Unit exit discharges and 1 of 2 East Unit corridors from obstructions per 19.2.1 LSC 19.2.1 states that every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.1.10. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice could affect staff and up to 10 residents.<br><br>Findings include:<br><br>Based on observation with the Administrator on 09/25/18 at 3:05 p.m. then again at 3:14 p.m., three separate chairs were in the East Unit nurse's station exit discharge. Then again, a commode chair was in the corridor outside of resident room RH 4. Based on interview at the time of each observation, the Administrator acknowledged that impediments such as the chairs were potential impediments to full use of the means of egress access corridors. | K 0211 | I. As of 9/25/2018 the East Unit exit door chairs were removed. The commode chair was removed immediately upon discovery.<br><br>II. Residents identified as having the potential to be affected would be those who are able to move freely without assistance. This exit is typically used by employees. Most residents residing on this unit are ventilator dependent or require total assist to exit.<br><br>III. On 10/15/2018 all staff will be in serviced regarding impediments in exits and hallways. The maintenance department has been instructed to monitor daily and correct or remove impediments.<br><br>IV. All department heads have been advised to monitor halls and exits daily for impediments to be removed. | 10/25/2018 |

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| | 3.1-19(b) | | V. Completion October 25, 2018 | |
| K 0222 SS=F Bldg. 02 | NFPA 101<br>Egress Doors<br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. | | | |

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| | 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>Based on observation, record review, and interview, the facility failed to ensure the facility failed to ensure 2 of 2 exterior exits had a code posted for locking devices that did not require special knowledge to open. LSC 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. This deficient practice could | K 0222 | I. As of 10/9/2018, all doors within the facility with delayed egress locking systems have codes posted by the number pads. Each posting is a one (1) inch post and clearly states number codes and symbols. The latch on the wooden gate on South Unit has been removed. The latch on the West nurse's station bathroom door has been removed. | 10/25/2018 |

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| AMBASSADOR HEALTHCARE | 705 E MAIN ST<br>CENTERVILLE, IN 47330 |

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| | affect staff and up to 25 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 between 12:50 p.m. and 5:06 p.m., the east exit doors were held in the locked position with a magnetic hold down device. Furthermore, the exit doors were equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A sign was near each keypad that read "*V V V *." Based on an interview at the time of each observation, the Maintenance Supervisor confirmed the V's were supposed to represent roman numerical number 5.<br><br>3.1-19(b) | | II. All residents residing in the facility have been identified as affected.<br><br>III. The Monthly Preventive Maintenance Log has been updated to include checking for accurate code postings and impediments to egress.<br><br>IV. Maintenance Supervisor will meet with the Administrator monthly to review PM Log to manage and monitor corrections or concerns regarding egress.<br><br>V. Completed October 25, 2018 | |
| K 0232<br>SS=E<br>Bldg. 02 | NFPA 101<br>Aisle, Corridor, or Ramp Width<br>Aisle, Corridor or Ramp Width<br>2012 EXISTING<br>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.<br>19.2.3.4, 19.2.3.5<br>Based on observation, the facility failed to meet 1 of 8 corridors clear width requirement exception per 19.2.3.4(5). LSC 19.2.3.4(5) requires where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture. LSC 19.2.3.4(5)(a) the fixed furniture is securely attached to the floor or to the wall. This deficient practice could affect staff and up to 15 residents. | K 0232 | I. The stools located at Room 104 and RH 7 have been removed and are no longer accessible to impede the requirements.<br><br>II. Residents residing on North Unit and Vent Unit are identified as having had the | 10/25/2018 |

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| | Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 between 12:50 p.m. and 5:06 p.m., a stool was located in the corridor outside of resident room RH 7. When tested, the stool was able to be moved around the corridor. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the stool was not secured to the floor or wall.<br><br>3.1-19(b) | | potential to be affected.<br><br>III. The inspection of corridors is now on the Monthly Preventative Maintenance Log. The Administrator held a maintenance department meeting on 10/4/2018 to inform and instruct on issues relating to Life Safety and proper monitoring and maintenance of the facility.<br><br>IV. The Maintenance Supervisor or designee is responsible to monitor corridors for clearance. QAPI will review quarterly for compliance.<br><br>V. Completion October 25, 2018 | |
| K 0361<br>SS=E<br>Bldg. 02 | NFPA 101<br>Corridors - Areas Open to Corridor<br>Corridors - Areas Open to Corridor<br>Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1.<br>18.3.6.1, 19.3.6.1<br>Based on observation and interview, the facility failed to ensure 2 of 8 corridors was separated from the corridors by a partition capable of resisting the passage of smoke in accordance with 19.3.6.1. This deficient practice could affect staff and up to 25 residents.<br><br>Findings include: | K 0361 | I. All outlet covers on the corridor ventilator alarms will be replaced by 10/25/2018.<br>II. All residents on the ventilator unit are identified as having the potential to be affected.<br>III. Outlet covers will be inspected by maintenance monthly and noted on the | 10/25/2018 |

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| | Based on observation with the Maintenance Supervisor on 09/25/18 between 12:50 p.m. and 5:06 p.m., the Vent Unit corridors contained a one inch penetration outside of each vent unit resident room alarm device. Based on interview at the time of observation, the Maintenance Supervisor confirmed the vent unit alarm devices caused a penetration and the cover left a gap in the drywall.<br><br>3.1-19(b) | | Preventative Maintenance Log. The Maintenance Supervisor and the Administrator will meet monthly to discuss preventative maintenance and interventions for corrections.<br>IV. Preventative Maintenance Log will be reviewed by the QAPI committee quarterly for recommended intervention, compliance, and monitoring.<br>V. Completion October 25, 2018 | |
| K 0363<br>SS=E<br>Bldg. 02 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that | | | |

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| | release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>Based on observation and interview, the facility failed to maintain protection of corridor doors in 1 of 8 corridors in accordance of 19.3.6.3. This deficient practice could affect staff and at least 15 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 3:20 p.m., resident room RH 4 contained a cart that was impeding the door from closing. Based on interview at the time of observation, the Maintenance Supervisor confirmed the door was impeded from fully closing and latching.<br><br>3.1-19(b) | K 0363 | I. The cart at RH 4 impeding door closure has been moved and room rearranged for complete door closure.<br><br>II. The resident residing in RH 4 is identified as having had the potential to be affected.<br><br>III. An in-service will be held with all staff on 10/15/18. The topic relating to complete door closure in the event of an emergency will be discussed. All department heads will be instructed to monitor door closure ability and report any issues to maintenance and the Administrator. All ventilator carts will be reviewed with Nursing and Respiratory Therapy for proper | 10/25/2018 |

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| | | | placement.<br><br>IV. Maintenance Supervisor, Nursing, and Respiratory Therapy are responsible to monitor cart placement as not to obstruct door closure.<br><br>V. Completion October 25, 2018 | |
| K 0372<br>SS=E<br>Bldg. 02 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 8 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff and at least 25 residents. | K 0372 | I. The gaps in the smoke barriers located at rooms 117, 121, and 202 have been repaired and sealed with fire caulk. The ½ inch gap around the sprinkler pipe and wires have also been sealed.<br><br>II. All residents residing on the North Unit, South 200 hall, and East Unit are | 10/25/2018 |

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| | Findings include:<br><br>Based on observations with the Maintenance Supervisor on 09/25/18 at 3:36 p.m., a half inch gap around sprinkler pipe in the East Unit attic smoke barrier. Additionally in the attic, a half inch gap around wires. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the cell phone photo taken of the gaps and provided the estimated measurements.<br><br>3.1-19(b) | | identified as having had the potential to be affected.<br><br>III. If any ceiling conduit or piping installations are made, the maintenance department will inspect after installation to insure wiring, etc. are sealed properly to prevent penetrations. The inspection will be logged on the Monthly PM Log.<br><br>IV. Maintenance department will monitor by performing a visual inspection monthly. Any needed interventions will be reported to the Administrator.<br><br>V. Completion October 25, 2018 | |
| K 0920<br>SS=E<br>Bldg. 02 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Electrical Equipment - Power Cords and Extension Cords<br>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 | | | |

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| | 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<br>1. Based on observation, record review, and interview, the facility failed to install 1 of 1 power strip according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 110.3(B) Installation and Use, states listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. This deficient practice affects staff and up to 15 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 3:19 p.m., a power strip was powering a resident bed, candle warmer, and a light in resident room RH 4. Based on interview at the time of observation, the Maintenance Supervisor confirmed patient care and non-patient care related items were being powered by a medical grade power strip.<br><br>3.1-19(b)<br><br>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 according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National | K 0920 | I. Maintenance assistants have removed non-medical electrical equipment from Room 129 power strip. The Laundry microwave was plugged directly to the wall outlet and surge protector removed. The surge protector was removed from HR and the refrigerator was plugged directly into the wall. The microwave in Room 134 was plugged directly to wall outlet. The refrigerator on East nurse's station is plugged directly to wall and surge protector removed. The surge protector in Telecom Room has been removed. After further inspection of RH4 no coffee pot or refrigerator are present in residents' room. Both residents are ventilator dependent and totally dependent on staff for care.<br><br>II. All residents residing in the facility are identified as having had the potential to be affected.<br><br>III. An in-service will be held on 10/15/18 to inform staff | 10/25/2018 |

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| | Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 15 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 3:19 p.m., a surge protector was powering a coffee pot and a refrigerator in resident room RH 4. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the high amperage devices in the surge protector. | | regarding hospital grade surge protector use. The maintenance department will check every resident room for proper compliant use and remedy as needed.<br><br>IV. Maintenance department will monitor by visual inspection monthly.<br><br>V. Completion October 25, 2018 | |
| K 0000<br><br>Bldg. 03 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 09/25/18<br><br>Facility Number: 000456<br>Provider Number: 155490<br>AIM Number: 100288750<br><br>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. | K 0000 | | |

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| | This two story facility with a partial basement was determined to be of Type V (111) construction and fully sprinkled except the second floor conference room closet. The facility has a fire alarm system with smoke detection on all levels including the partial basement, the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 126 at the time of this visit.<br><br>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the detached storage building and the detached walk in cooler and walk in freezer.<br><br>Quality Review completed on 10/01/18 - DA | | | |
| K 0222 SS=D Bldg. 03 | NFPA 101<br>Egress Doors<br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 | | | |

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| | SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised | | | |

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| | automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>Based on observation and interview, the facility failed to ensure 1 of 1 West Unit Nurse's station bathroom doors was arranged such that egress cannot be restricted. This deficient practice could affect staff and up to 1 resident.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 1:38 p.m., the West Unit Nurse's station bathroom door had an eye hook latching mechanism on the outside of the door. Based on interview at the time of observation, the Maintenance Supervisor confirmed a resident could be prevented from leaving if the latch was applied and immediately removed the latching device.<br><br>3.1-19(b) | K 0222 | I. As of 10/9/2018, all doors within the facility with delayed egress locking systems have codes posted by the number pads. Each posting is a one (1) inch post and clearly states number codes and symbols. The latch on the wooden gate on South Unit has been removed. The latch on the West nurse's station bathroom door has been removed.<br><br>II. All residents residing in the facility have been identified as affected.<br><br>III. The Monthly Preventive Maintenance Log has been updated to include checking for accurate code postings and impediments to egress.<br><br>IV. Maintenance Supervisor will meet with the Administrator monthly to review PM Log to manage and monitor corrections or concerns regarding egress.<br><br>V. Completed October 25, 2018 | 10/25/2018 |
| K 0225<br>SS=D<br>Bldg. 03 | NFPA 101<br>Stairways and Smokeproof Enclosures<br>Stairways and Smokeproof Enclosures<br>Stairways and Smokeproof enclosures used | | | |

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|---|---|---|---|
| | 155490 | A. BUILDING 03<br>B. WING | 09/25/2018 |

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

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| | as exits are in accordance with 7.2.<br>18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2<br>Based on observation and interview, the facility failed to maintain 1 of 2 West Unit stairwells free from storage in accordance with 7.2.2.5.3.1. LSC 7.2.2.5.3.1 states open space within the exit enclosure shall not be used for any purpose that has the potential to interfere with egress. This deficient practice could affect staff and up to 4 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 1:39 p.m., the south stairwell contained copier and a shop vacuum. Based on observation, the Maintenance Supervisor confirmed there was storage underneath the stairwell.<br><br>3.1-19(b) | K 0225 | I. As of 10/9/2018 all items in stairwells have been removed to suitable storage.<br><br>II. Residents residing on North Unit are identified as having had a potential to be affected. The West stairwell could affect residents on the West Unit. The stairwell is not accessible to residents.<br><br>III. Monthly inspections of all storage areas are now placed on the Monthly Maintenance Log.<br><br>IV. Maintenance Supervisor will inspect and monitor all stairwells and egress for appropriate clearance and report to QAPI committee quarterly.<br><br>V. Completion October 25, 2018 | 10/25/2018 |
| K 0311<br>SS=E<br>Bldg. 03 | NFPA 101<br>Vertical Openings - Enclosure<br>Vertical Openings - Enclosure<br>2012 EXISTING<br>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.<br>19.3.1.1 through 19.3.1.6<br>If all vertical openings are properly enclosed | | | |

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| | with construction providing at least a 2-hour fire resistance rating, also check this box.<br>Based on observation and interview, the facility failed to maintain protection of 2 of 2 stairways in accordance of 19.3.1. LSC 19.3.1.1 requires where an enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. This deficient practice could affect staff and at least 14 residents in the smoke compartment.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 1:12 p.m., the North and South stairwells doors at the top and bottom did not have a fire resistance rating tag. Additionally, the North first floor stairwell door caught on the carpet when fully opened. Based on interview at the time of observation, the Maintenance Supervisor confirmed the four stairwell doors did not have a fire resistive label to confirm at least a forty five minutes rating and the door failed to fully self-close when tested.<br><br>3.1-19(b) | K 0311 | I. The north and south facing doors on the West Unit will be replaced with doors having a fire-resistant rating of at least one (1) hour.<br><br>II. All residents on the West Unit are identified as having had the potential to be affected.<br><br>III. All doors facility wide will be inspected for appropriate fire rating standards. Appropriate corrections or replacements will be accomplished for any deficiency.<br><br>IV. Maintenance Supervisor and the Administrator will monitor for compliance of outcome and inspection.<br><br>V. Completion October 25, 2018 | 10/25/2018 |
| K 0363<br>SS=E<br>Bldg. 03 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>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 | | | |

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| | to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that 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.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. | | | |
| | Based on observation and interview, the facility failed to maintain protection of corridor doors in 1 of 2 West Unit 1st floor corridors in accordance of 19.3.6.3. This deficient practice could affect staff and at least 14 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance | K 0363 | I. A new electric magnet door closure has been ordered through contracted vendor to be installed by 10/25/18. Once the electric magnet has been installed, the slide bolt will then be removed. The door swings freely if removed. Room 6 latch has been repaired. The door closes securely | 10/25/2018 |

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| | Supervisor on 09/25/18 between 1:18 p.m. and 1:47 p.m., the following was discovered:<br>a) West Unit cross corridor double doors contained a manual slide bolt on the top and bottom of one of the doors<br>b) resident room 6 failed to latch into the frame when tested<br>c) a cushioned floor pad impeded resident room 4 from fully closing<br>Based on interview at the time of each observation, the Maintenance Supervisor confirmed the cross corridor entrance/exit double doors were not smoke barriers and confirmed the doors failed to fully close and latch.<br><br>3.1-19(b) | | in the frame. The floor pad has been moved so that the door fully closes.<br><br>II. All residents residing on the West Unit are identified as having had the potential to be affected.<br><br>III. On 10/15/18 an in-service will be held with all staff instructing use of floor pads. Maintenance will monitor function of all magnetic locks on doors and smoke barriers. Maintenance will document function on the Preventative Maintenance Log.<br><br>IV. Maintenance will check all magnetic locks and smoke barriers monthly and document function on the Preventative Maintenance Log. The log will be reviewed with the Administrator monthly for any compliance intervention.<br><br>V. Completion October 25, 2018 | |
| K 0000<br><br>Bldg. ID | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 09/25/18 | K 0000 | | |

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| | Facility Number: 000456<br>Provider Number: 155490<br>AIM Number: 100288750<br><br>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.<br><br>This two story facility with a partial basement was determined to be of Type V (111) construction and fully sprinkled except the second floor conference room closet. The facility has a fire alarm system with smoke detection on all levels including the partial basement, the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 126 at the time of this visit.<br><br>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the detached storage building and the detached walk in cooler and walk in freezer. | | | |
| K 0353<br>SS=D<br>Bldg. ID | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>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 | | | |

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| | secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 West Unit basement. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff only.<br><br>Findings include:<br><br>Based on observation with the Maintenance Supervisor on 09/25/18 at 1:39 p.m., the West Unit basement was missing at least seven ceiling tiles. Based on interview at the time of observation, the Maintenance Supervisor was unaware of the missing ceiling tiles.<br><br>3.1-19(b) | K 0353 | I. The monthly control valve inspection and weekly dry system gauge has been completed. The ceiling tiles have been replaced and secured as of 9/26/18.<br><br>II. All residents residing in the facility are affected as having had the potential to be affected.<br><br>III. Weekly visual inspections will be done by Maintenance Supervisor. This inspection will be documented on the Weekly Control Valve Inspection Log. Ceiling inspections will be documented on the Weekly PM Log.<br><br>IV. Maintenance Supervisor must submit logs quarterly to QAPI committee for review.<br><br>V. Completion October 25, 2018 | 10/25/2018 |