STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155490	A. BUILDING 01 B. WING	08/30/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/30/17 Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750 At this Life Safety Code survey, Ambassador Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a partial basement 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	K 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	all resident sleeping rooms. The facility has a capacity of 137 and had a census of 111 at the time of this visit. 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. Quality Review completed on 09/11/17 - DA			
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 1 of 7 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall.	K 0232	On 08/31/2017 chair was removed from hallway. The 20 residents of North hall have been identified as having been affected. Maintenance Staff will be required to check corridors weekly for equipment or other furnishing for proper placement. Staff will place items within LSC guidelines immediately if	09/29/2017

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	(b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 20 residents who reside on the North Hall. Findings include: Based on observation with the		non-compliance occurs. Maintenance Supervisor will monitor newly created log form and monthly for compliance. Follow up will be presented to the QAPI committee monthly for additional monitoring.	

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	maintenance supervisor on 08/30/17 at 11:40 a.m., the North Hall corridor near the nurses' station, which measured eight feet wide, had a lounge chair stored in the corridor which reduced the corridor width to five feet six inches and was not firmly affixed to the floor or wall. Based on interview at the time of the observation and measurement with the maintenance supervisor, it was stated the North Hall corridor lounge chair is stored in the corridor for resident use. 3.1-19(b)			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all	K 0346	The fire watch policies and procedures has seen updated to include the ISDH Gateway plus contingences for non-operational website. An in-service was held on 09/15/2017 with the dietary staff on range hood fire suppression system.	09/29/2017

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	occupants. Findings include: Based on record review with the administrator and maintenance supervisor on 08/30/17 at 8:43 a.m., the facility provided Fire Watch Policy and Procedure documentation but it was incomplete. The Fire Watch Policy and Procedure plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. and lacked a properly trained staff member who was to perform the fire watch. Based on interview during the record review, the administrator and maintenance supervisor confirmed the fire watch documentation provided labeled Fire Watch Policy stated to contact the Indiana State Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above and lacked a properly trained staff member who was to perform the fire watch. 3.1-19(b)		Additionally, on 09/29/2017 a mandatory in-service for all staff will be held to inform of the policy and procedure on fire watch plus range hood suppression policies and procedures. All residents residing in the facility are identified as having been affected. Administrator and Maintenance Supervisor will review policies and procedures with QAPI. Maintenance Supervisor will report to QAPI monthly regarding fire watch incidents that occurred. Maintenance Supervisor will schedule semi-annual in-services reviewing fire safety watch, fire extinguishers, and range suppression systems. Maintenance Supervisor will monitor annual in-servicing on fire safety and policies.	

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K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview, the facility failed to document monthly sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with	K 0353	As of 09/13/2017, Sprinkler system was inspected and tested per contracted fire protection service company. Administrator and Maintenance Supervisor informed company at that time to inspect system monthly starting 09/13/2017. Additionally, new gauges were installed. As of 09/15/2017 a new sprinkler was installed in the kitchen mop closet. 42 residents potentially using North dining room and identified has potential	09/29/2017

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	locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. This deficient practice could affect all residents in the facility. Findings include: Based on record review with the maintenance supervisor on 08/30/17 at 9:25 a.m., the Koorsen Fire and Security quarterly sprinkler inspections dated 06/20/17, 03/21/17 indicated the 600 Hall sprinkler riser room two control valves and two sprinkler gauges and the basement sprinkler riser one control valve and two sprinkler gauges were visually inspected during each quarterly inspection. Based on an interview with the maintenance supervisor on 08/30/17 at 9:30 a.m., it was indicated the facility does not perform monthly inspections on the three control valves and four sprinkler system gauges. The lack of monthly sprinkler system gauge and control valve inspections was confirmed by the maintenance supervisor at the time of record review and interview. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 300 sprinklers in the facility which was		being affected. Monthly visual inspection on all sprinkler heads will be done by the maintenance department and logged in the monthly monitoring log. Maintenance supervisor will assign the task to maintenance department and required log submitted to him for completion. Maintenance Supervisor will submit monthly monitoring report to QAPI.	

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	corroded was replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 42 residents who use the main dining room located adjacent to the kitchen. Findings include: Based on observation on 08/30/17 at 12:40 p.m. with the maintenance supervisor, the kitchen mop closet sprinkler was completely covered in green corrosion. This was confirmed by the maintenance supervisor at the time of observation. 3.1-19(b)			
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has			

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	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. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)			
	Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed for the protection of 111 of 111 residents 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 in the facility. Findings include: Based on record review with the administrator and maintenance supervisor	K 0354	The fire watch policies and procedures has seen updated to include the ISDH Gateway plus contingences for non-operational website. 09/29/2017 a mandatory in-service for all staff will be held to inform of the policy and procedure on fire watch plus range hood suppression policies and procedures. All residents residing in the facility are identified as having been affected. Administrator and Maintenance Supervisor will review policies and procedures with QAPI. Maintenance Supervisor will report to QAPI monthly regarding fire watch	09/29/2017

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	on 08/30/17 at 8:43 a.m., the facility provided Fire Watch Policy and Procedure documentation but it was incomplete. The Fire Watch Policy and Procedure plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. and lacked a properly trained staff member who was to perform the fire watch. Based on interview during the record review, the administrator and maintenance supervisor confirmed the fire watch documentation provided labeled Fire Watch Policy stated to contact the Indiana State Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above and lacked a properly trained staff member who was to perform the fire watch. 3.1-19(b)		incidents that occurred. Maintenance Supervisor will schedule semi-annual in-services reviewing fire safety watch, fire extinguishers, and range suppression systems. Maintenance Supervisor will monitor annual in-servicing on fires safety and policies.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING			

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	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. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 8 attic smoke barriers had a minimum of a 1/2 hour fire resistive rating and the penetrations caused by the passage of wire and/or conduit through 1 of 8 attic smoke barrier walls was protected to maintain the smoke resistance of the 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 18 residents who reside on the House Hall. Findings include: Based on observation on 08/30/17 at during a tour of the attic smoke barriers from 2:35 p.m. to 3:00 p.m. with the maintenance supervisor, the House Hall attic smoke barrier wall had three one quarter inch penetrations from electrical conduit not fire stopped and a seven foot	K 0372	As of 09/15/2017, the smoke barrier wall on the entry to west/house hall has been repaired and sealed with 5/8" FC drywall plus sealed with fire caulk. The 18 residents on west hall have been identified as having the potential to be affected. Maintenance Supervisor will perform monthly checks of all smoke barrier spaces. Maintenance Supervisor will log conditions and actions necessary to ensure walls are impenetrable. If issues arise, action to repair will be done immediately. Maintenance Supervisor will report to monthly QAPI Committee meeting the results of inspection and repairs if required for monitoring.	09/29/2017

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	by twelve inch section of drywall at the bottom of the attic smoke barrier wall crumbling and breaking from the wooden rafters. This was confirmed by the maintenance supervisor at the time of observation. 3.1-19(b)			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 2 of 8 corridor smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the	K 0374	As of 08/31/2017 doors have been adjusted and repaired to fully closed. 38 residents residing on North and East hall have been identified as having the potential to be affected. The Maintenance department will be assigned	09/22/2017

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	minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 38 residents who reside on the North Hall and the East Hall. Findings include: Based on observation on 08/30/17 during a tour of the facility from 11:31 a.m. to 3:00 p.m. with the maintenance supervisor, the North Hall corridor smoke barrier door set and the East Hall corridor smoke barrier door set each had a one inch gap along the center of the smoke barrier doors where the doors came together in the closed position. This was confirmed by the maintenance supervisor at the time of observations. 3.1-19(b)		to check all smoke barrier doors and log actions plus monthly repairs as necessary. Logs of inspection of doors will be completed to ensure proper closure of doors and will be submitted to Maintenance Supervisor. Maintenance Supervisor will submit report to QAPI monthly reviewing fire safety and what action is required on smoke barrier doors.	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2.			

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	18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on record review on 08/30/17 at 8:45 a.m. with the administrator and maintenance supervisor, the facility's fire disaster plan labeled Disaster and Emergency Response lacked the transmission of the fire alarm system to the fire department and lacked the	K 0711	In review of policies and procedures relating to evacuation and relocation plan. Polices were present in the facility at the time of survey. An old policy was unfortunately given to surveyor at the time of survey. On 09/15/2017, an in-service was given to all dietary staff on K class fire extinguisher, range hood suppression, and educated on alarms to fire department. An additional in-service is scheduled for all staff on 09/29/2017 to K class fire extinguisher, range hood suppression, and educated on alarms to fire department. A semi-annual in-service will be scheduled with the Clinical Educator for the K class fire extinguisher, range hood suppression, and educated on alarms to fire department. All residents residing in the facility have the potential to be affected.	09/29/2017

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	155490	A. BUILDING 01 B. WING	08/30/2017

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	kitchen staff use of the K class fire extinguisher and its use in relationship to the overhead hood extinguishing system. This was confirmed by the administrator and maintenance supervisor at the time of record review. 3.1-19(b)		The clinical educator will schedule semi-annual in-services to cover fire safety and all topics relating to the disaster plan along policies and procedures. Additionally, an emergency disaster fair has been planned for 09/20 and 09/21. Fire safety is included in the fair. In-service schedule/planning will be submitted to the QAPI committee monthly. Clinical educator will monitor the needs of the facility and residents.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Based on record review and interview,	K 0712	After further review of fire	09/29/2017

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	the facility failed to conduct quarterly fire drills on 1 of 3 shifts and 1 of 4 quarters over the past year. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Fire Drill Reports on 08/30/17 at 9:35 a.m. with the administrator and maintenance supervisor, there was no record of a fire drill conducted on the third shift for the second quarter of the year 2017. Based on an interview with the maintenance supervisor at the time of record review, there are no other records to indicate the missing fire drills had been conducted. 3.1-19(b)		drill records third shift fire drill for second quarter of 2017 was discovered after survey. An additional third shift fire drill was held on 09/16/2017 to correct the alleged noncompliance. All residents residing in the facility are identified as having the potential to be affected. A yearly calendar has been created to reflect each monthly fire drill. This will be monitored by the Maintenance Supervisor for completion of each drill. Maintenance Supervisor will report drill monthly to QAPI committee meeting for review and monitoring.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power			

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	strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, it could not be assured 9 of 60 resident rooms patient care vicinities met UL UL60601-1 requirements. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. This deficient practice could affect 12 residents who reside in rooms 135, 133, 129, 125, 123, and 107, and 3 residents who reside in rooms RH20, RH16 and RH2.	K 0920	On 09/18/2017 UL 60601-1 power strips were ordered for the residents' use. The Maintenance staff has checked all resident's rooms for non-compliant power strips for replacement. All residents/resident representatives will be notified of the restrictions of use of common household power strips. A statement also will be placed in admissions information packet to inform future residents of the restriction of these devices. All residents that have non-compliant power strips are identified as been affected. Maintenance department will check all rooms monthly	09/29/2017

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	Findings include: Based on observations with the maintenance supervisor during a tour of the facility on 08/30/17 from 11:31 a.m. to 3:00 p.m., resident rooms 135, 133, 129, 125, 123, 107, RH20, RH16, and RH2 each had a power strip in use to power television sets, floor fans, telephone chargers, and bedside lights within six feet of the beds and lacked a UL60601-1 listing on each power strip used. This was confirmed by the maintenance supervisor at the time of observations. 3.1-19(b)		for non-compliance and replace with compliant power strips as needed. Maintenance Supervisor will provide QAPI with results of this monthly review.	