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	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Healthcare	705 E Main St Centerville, IN 47330

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 25054 Based on interview and record review, the facility failed to complete a thorough investigation of the root cause of a fall and failed to implement a fall intervention for 1 of 3 residents reviewed for accidents (Resident B). Findings include: Review of the clinical record for Resident B, on 1/7/25 at 1:30 p.m., indicated the diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic pain, hypertension, hypertensive heart disease, muscle weakness, need for assistance with personal care, dementia, abnormal gait, anxiety, and osteoarthritis. A progress note for Resident B, dated 12/2/24 at 1:57 a.m., indicated the resident pushed the call light and was found on the floor next to the bed. The resident stated she had a headache prior to the fall and when she got out of the bed, she slid to the floor. The resident denied hitting her heard. There were no injuries noted. The resident was assisted back to bed. The resident indicated she was going to get a clean shirt and was assisted with changing her shirt. The physician was notified. A progress note for Resident B, dated 12/2/24 at 3:57 a.m., indicated the staff were checking on the resident often during the night. The resident was found sitting on the floor next to her bed. The resident indicated she was sitting on the side of the bed and slid off. There were no injuries noted. The resident was assisted back to bed. The resident's bed was in the lowest position and call light was in reach. The physician was notified. This progress note was struck out with lines through it, dated 12/2/24 at 8:04 a.m., with the strike out reason being Duplicate order. The physician fax notification for Resident B, dated 12/2/24, indicated the resident had a headache and slid to the floor when she was trying to get out of bed, denied hitting her head, and no injuries were noted. The resident slid to the floor again, at 3:50 a.m., with no injuries. The resident fell at 1:45 a.m. and 3:50 a.m., on 12/2/24. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note for Resident B, dated 12/2/24 at 9:40 a.m., indicated the Interdisciplinary Team (IDT) met to discuss the resident's fall from earlier that morning. The staff responded to a call light and found the resident on the floor next to the bed. Resident stated when she got up, she slid to the floor. She denied hitting her head and had no noted injuries. The resident stated she was going to get a clean shirt to change into. The resident was assisted with changing her shirt. The staff were to ensure nonskid footwear was in place at all times. Therapy department was made aware, and the plan of care was reviewed and updated. The plan of care for Resident B, dated 7/12/24, indicated the resident was at risk for falls due to new admission, COPD, dementia, osteoarthritis, hypertension, hypertensive heart disease, chronic pain, and sciatica. The interventions included, but were not limited to, (12/2/24) nonskid footwear to be in place at all times. The fall risk assessment for Resident B, dated 12/2/24 at 8:43 a.m., indicated the resident was at moderate risk for falls. During an interview with Certified Nurse Aide (CNA) 1 on 1/7/25 at 2:40 p.m., she indicated she was caring for Resident B, on 12/2/24, when the resident fell . CNA 1 indicated the resident fell twice, on 12/2/24, and both falls were close to the bed in her room. The first time Resident B fell she was sitting on her bottom and the second time she fell ; she was on her knees. The nurse was Licensed Practical Nurse (LPN) 2 and she assessed her after both falls. CNA 1 indicated no facility management staff spoke to her about Resident B falling on 12/2/24. During an interview with LPN 2 on 1/7/25 at 3:00 p.m., she indicated she was the nurse caring for Resident B, on 12/2/24, when she fell . LPN 2 indicated the resident was confused that night and kept trying to mess with her clothes. The first time Resident B fell she said she was going to the bathroom and the second time she fell she was going to her closet. The resident fell twice, on 12/2/24, and LPN 2 notified the physician of both falls. LPN 2 indicated no facility management staff had spoken to her about Resident B's falls on 12/2/24. During an interview with the Director of Nursing (DON) on 1/8/25 at 11:36 a.m., she indicated she did not know Resident B fell twice on 12/2/24. She thought it was duplicate documentation. The DON indicated the protocol of investigating falls was through chart review and observing the camera footage. The DON indicated there were no cameras in resident rooms. The fall policy provided by the DON, on 1/7/25 at 1:20 p.m., indicated the staff would identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input from the attending physician, would identify appropriate intervention(s) to reduce the risk of falls. The examples of initial approaches might include exercise, balance training, and/or rearrangement of room furniture. If a medication was suspected as a possible cause of a resident falling, the initial intervention might be to taper or stop medications. If falling recurs despite the initial interventions, staff would implement additional or different interventions. This citation relates to Complaint IN00449305. 3.1-45(a)(1) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-45(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 25054 Based on interview and record review, the facility failed to have complete and accurate documentation of a resident's fall for 1 of 3 residents reviewed for accidents (Resident B). Findings include: Review of the clinical record for Resident B, on 1/7/25 at 1:30 p.m., indicated the diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic pain, hypertension, hypertensive heart disease, muscle weakness, need for assistance with personal care, dementia, abnormal gait, anxiety, and osteoarthritis. A progress note for Resident B, dated 12/2/24 at 3:57 a.m., indicated the staff were checking on the resident often during the night. The resident was found sitting on the floor next to her bed. The resident indicated she was sitting on the side of the bed and slid off. There were no injuries noted. The resident was assisted back to bed. The resident's bed was in the lowest position and call light was in reach. The physician was notified. This progress note was struck out with lines through it, dated 12/2/24 at 8:04 a.m., with the strike out reason being Duplicate order. During an interview with Licensed Practical Nurse (LPN) 2 on 1/7/25 at 3:00 p.m., she indicated she was Resident B's nurse, on 12/2/24, when the resident fell twice. LPN 2 indicated she noticed her documentation about the second fall was marked out and she did not know why or who did it. During an interview with the Director of Nursing (DON) on 1/8/25 at 11:36 a.m., she indicated she struck out the progress note on Resident B, dated 12/2/24 at 3:57 a.m., because she thought it was duplicate documentation. The charting and documentation policy provided by the DON, on 1/8/25 at 12:03 p.m., indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record would be complete and accurate. This citation relates to Complaint IN00449305. 3.1-50(a)(1) 3.1-50(a)(2)