

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Ambassador Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of verbal abuse was reported to the Indiana Department of Health within two (2) hours of its receipt for 1 of 3 residents reviewed for abuse. (Resident D) Findings include: In an interview with Resident D on 7-17-25 at 11:20 a.m., she indicated a physical therapist (PT 3) had been rude to her in the recent past when PT 3 told her, Show me what you can do, indicating this occurred after she had kicked me off of physical therapy. She indicated she promptly shared this information with the Social Services Staff and the Executive Director. In an interview with the Executive Director (ED) on 7-17-25 at 1:15 p.m., the ED indicated he did not report this as an allegation of abuse to the state. He indicated as soon as the facility began their investigation, it was very clear it was not abuse, but merely the resident being told something that she did not want to hear by the PT, who tends to be rather direct. On 7-17-25 at 10:36 a.m., the ED provided a copy of a policy entitled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program. This policy indicated, Residents have the right to be free from abuse, neglect, but it is not limited to freedom from verbal abuse. Identify and investigate all possible incidents of abuse. Investigate and report any allegations within timeframes required by federal requirements. This citation relates to Complaint IN00462662. 3.1-28(c)</p>

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
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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>(continued on next page)</p>

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was referred for home health nursing services upon discharge for 1 of 3 residents reviewed for discharge. (Resident B) Findings include: The clinical record for Resident B was reviewed on 7/17/25 at 11:10 a.m. His diagnoses included, but were not limited to, mechanical complication of internal left knee prosthesis, infection and inflammatory reaction due to internal left knee prosthesis, hypertension, and type 2 diabetes mellitus. He was admitted to the facility on [DATE] and discharged on 6/18/25. The 6/7/25 admission MDS (Minimum Data Set) assessment indicated he was cognitively intact. An interview was conducted with Resident B on 7/18/25 at 3:03 p.m. He indicated he had an infection in his leg and was on IV (intravenous) antibiotics four times a day while at the facility. When he was discharged from the facility on 6/18/25, they should have ordered nursing services for him, not just therapy. He wasn't able to get the IV antibiotics anymore but was supposed to be on them for two more weeks. It was almost a week after discharge, before he got everything figured out, but by that time, he'd already been off the antibiotics for a week. He was discharged from the facility with home health, but when the home health company contacted him after discharge, they informed him they only had an order for therapy. There were no orders for nursing, including the care of his PICC (peripherally inserted central catheter.) The first time the home health nurse came to see him, she just looked at the PICC, to ensure there were no signs of infection, because she had no orders. By the time it was straightened out and he was seen by a nurse from home health, his PICC dressing was overdue for a dressing change, as it had been almost two weeks since it was changed. Eventually, his PCP (primary care physician) wrote an order for home health to pull the PICC. Resident B's ID (infectious disease) physician was on leave at the time, so they were unable to write an order. He stated, If the facility had sent over the proper orders, I would have had what I needed. Someone from the facility came to speak with him, on 6/18/25, about the Medicaid application process, and he left the facility five hours later. He left with a 30-day supply of some medicine, two administrations of antibiotics, and some discharge paperwork, but no orders. On 7/17/25 at 2:21 p.m., an interview was conducted with the local hospital's social worker, where Resident B's Infectious Disease physician's office was associated. She indicated they were concerned with him discharging from the facility with a PICC in place and no follow-up for antibiotic treatment. Their office was informed when Resident B called and tried to set up getting his antibiotics taken care of after leaving the facility. The 5/30/25 medical professional progress note indicated the reason for the visit was debility, hypertension, failed total knee arthroplasty, obesity, diabetes mellitus, type 2, and left knee wound dehiscence. He was admitted to a local hospital, on 5/19/25, with a left total knee prosthetic joint infection, left total knee open dislocation, and traumatic arthrotomy of the left knee. He was transferred from the hospital to the facility, on 5/29/25, for continued skilled nursing care and rehabilitation. He was currently receiving IV antibiotics via a PICC line, with treatment scheduled to continue until 6/30/25. His admission to the facility included management of ongoing medical conditions, administration of IV antibiotics, and participation in physical and occupational therapy to aid in recovery. The Assessment and Plan section of the note indicated for the infection associated with prosthesis for left knee joint was to continue IV Cefepime as ordered until 6/30/25 and follow up in one week. The facility physician's orders indicated to administer one IV application of Daptomycin-Sodium Chloride Intravenous Solution 700-0.9 mg/100ML-% at bedtime, effective 5/31/25 until 6/30/25; to administer one IV application of Cefepime HCl Intravenous Solution 1 GM/50ML (one gram/50 milliliters) every 8 hours, effective 5/30/25 until 6/30/25; to change the sterile PICC dressing once a week and as needed if soiled, every evening shift every Saturday, from 6/2/25 to 6/7/25, and starting 6/14/25; to flush the PICC with 3-5 cc (three to five cubic centimeters) of saline, administer antibiotic, then flush with heparin followed by saline, every shift, effective 5/30/25; and to change the IV tubing every 24 hours for PICC line/IV antibiotic, effective 5/29/25. The 6/2/25 hospital follow up note indicated he was two weeks status post left knee resection arthroplasty incision. He was currently receiving Cefepime and Daptomycin per ID recommendation. He was doing relatively well. They would see him back in one week for possible staple removal and to check progress. He was to continue with IV antibiotics per infectious disease recommendation. The 6/18/25 nurses note indicated, Resident discharged from facility to home with family. All discharge paperwork signed and sent with resident's family. Sent inhaler, atb [antibiotic], insulin with resident/resident's family. Home health script [prescription] sent with family. No issues, complaints or</p>		