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	05/13/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview, observation and record review, the facility failed to ensure residents maintained dignity by assisting residents with toileting needs in a timely manner, resulting in incontinence for 1 of 4 residents reviewed for resident rights. (Resident 14) Findings Include: The clinical record for Resident 14 was reviewed on 5/7/26 at 12:05 p.m. The resident's diagnoses included, but were not limited to: morbid obesity (body mass index of 40 or higher), essential tremors (progressive neurological disorder that caused involuntary rhythmic shaking), mononeuropathy of bilateral upper limbs (damage to or compression of individual peripheral nerves in both arms or hands), and chronic pain syndrome. The care plan, dated 10/3/25 and revised 12/19/25, indicated Resident 14 had occasional episodes of bladder incontinence. An intervention was to provide moderate assistance with toilet transfers and hygiene. An interview was conducted with Resident 14 on 5/7/26 at 12:16 p.m. The resident indicated she could usually get herself onto the commode, but she needed assistance with wiping afterwards. She would wait twenty minutes for staff to come assist her with wiping after she pressed her call light. When staff finally came to assist, she was sitting in a dirty brief from having had a bowel movement and inability to wipe herself. An interview was conducted with CNA (Certified Nursing Assistant) 5 on 5/12/26 at 10:50 a.m., the CNA indicated she worked with Resident 14 roughly once a week. The resident needed extensive assistance with hygiene. Resident 14 did not need help transferring onto or off the commode, only with wiping afterwards and pulling her pants back up. The resident used her bathroom call light to ask for assistance. CNA 5 hadn't known Resident 14 to assist herself off the commode. She usually always used her call light. An interview was conducted with Resident 14 on 5/12/26 at 11:11 a.m., the resident indicated that morning she pressed her call light around 7:15 a.m., and she didn't get assistance until 8:00 a.m. The resident normally took herself to the bathroom, but today she needed assistance onto the toilet. CNA 7 was the one who assisted her onto the commode. When CNA 7 assisted her, CNA 7 informed Resident 14 she had to get breakfast trays out, and that was why it took her so long to answer her call light. Resident 14 understood that, but the facility still needed staff to assist residents with going to the restroom. An interview was conducted with CNA 7 on 5/12/26 at 11:29 a.m., the CNA indicated she assisted Resident 14 onto the commode after breakfast, around 8:00 a.m. CNA 7 did not know how long Resident 14's call light was on, before she answered it to assist her. CNA 7 was assisting another (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident with eating, so when she finished, she went into Resident 14's room to help her. CNA 7 could hear Resident 14's call light going off while assisting the other resident, but she did not want to leave the other resident. The other CNA working the hall was assisting another resident at the time too. Resident 14 informed CNA 7 that her call light had been on for 45 minutes. An interview was conducted with RN (Registered Nurse) 8 on 5/12/26 at 11:29 a.m., the RN indicated she was in and out of rooms passing medications during that timeframe and did not see Resident 14's call light on. No one was sitting at the nurse's desk during that timeframe either, because everyone was very busy An interview was conducted with the DON (Director of Nursing) on 5/12/26 at 11:36 a.m., the DON indicated Resident 14 was a fairly reliable source of information but found a 45 minute wait time hard to believe. She could see 15 to 20 minutes, especially during mealtimes. Typically, a five-to-ten-minute wait time was fine. An interview was conducted with the DON on 5/13/26 at 10:55 a.m., the DON indicated she looked at the facility's cameras and found Resident 14's call light was on 24 minutes before CNA 7 went into the room to assist her. It was turned on at 7:38 a.m. and turned off at 8:02 a.m. An interview was conducted with Resident 14 on 5/13/26 at 11:18 a.m., the resident indicated she was agitated while waiting for someone to come and assist her to the restroom. It was hard to hold it in while waiting, and her stomach was cramping. The Residents Call System policy was provided by the ED (Executive Director) on 5/12/26 at 12:52 p.m. It indicated, Calls for assistance are answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately. During a confidential interview conducted during the survey, from 5/6/26 through 5/13/26, the confidential interview indicated the staff walked by or entered a residents room and stated they would get help, but it took hours to receive assistance from the toilet. By the time staff assisted the residents, they had already experienced bowel and bladder incontinence. A policy entitled, Resident Rights, was provided by the Administrator on 5/13/2026 at 9:52 AM. The policy indicated resident had the right to be treated with kindness, dignity, and respect. 410 IAC (Indiana Administrative Code) 3.1-3(a)410 IAC 3.1-38(a)(2)(C)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview, and record review, the facility failed to honor a resident's bathing time preference for 1 of 1 resident reviewed for choices. (Resident 14)Findings include:The clinical record for Resident 14 was reviewed on 5/7/26 at 12:05 p.m. The resident's diagnoses included, but were not limited to: morbid obesity (body mass index of 40 or higher), essential tremors (progressive neurological disorder that caused involuntary rhythmic shaking), mononeuropathy of bilateral upper limbs (damage to or compression of individual peripheral nerves in both arms or hands), and chronic pain syndrome. The activities of daily living (ADL) care plan, revised on 12/19/25, indicated the resident required moderate assistance with self-care and mobility tasks related to weakness. An intervention was for staff to assist her with any areas of bathing she could not complete, initiated 10/3/25. The preferences and specifications care plan, revised 12/19/25, indicated the resident preferred to take a shower in the morning. An interview was conducted with Resident 14 on 5/7/26 at 12:11 p.m. The resident indicated she was fine with her scheduled shower days of Wednesday and Saturday, but she wanted to take them in the morning, not at night. She received more of them at night than she did in the morning. An interview was conducted with Certified Nursing Assistant (CNA) 5 on 5/12/26 at 10:50 a.m. The CAN indicated she worked at the facility with Resident 14 roughly once a week. Resident 14 required extensive assistance of one staff person for showers. She worked from 10:00 a.m. to 6:00 p.m. She had never given Resident 14 a shower, because she did not work during Resident 14's scheduled shower time. When she arrived at the facility, Resident 14 was always already up and dressed. Her showers weren't until the evening time. An observation of the shower schedule posted on the shower room door and interview was conducted with CNA 5 on 5/12/26 at 10:53 a.m. The schedule indicated Resident 14's shower was scheduled for second shift on Saturdays and Wednesdays. CNA 5 indicated second shift was 2:00 p.m. to 10:00 p.m., but Resident 14 received her showers after CNA 5 left at 6:00 p.m. An interview was conducted with Resident 14 on 5/12/26 at 11:11 a.m. The resident indicated when staff waited until 7:00 p.m. to offer her a shower, she ended up telling them she didn't want one anymore, because it was too late for her by then. An interview was conducted with the Director of Nursing (DON) on 5/12/26 at 11:36 a.m. The DON indicated the CNAs were giving showers based on residents' room numbers, instead of each resident's actual preference, but they were working on getting that process fixed. CNA 6 worked with Resident 14 more regularly and would have more insight into when Resident 14 received her showers. An interview was conducted with CNA 6 on 5/12/26 at 2:32 p.m. The CNA indicated she always assisted Resident 14 with her showers before she left at 6:00 p.m., but it was not necessarily in the morning. It was usually before 2:00 p.m. The Resident Self Determination and Participation policy was provided by the Executive Director (ED) on 5/12/26 at 12:52 p.m. It indicated, Each resident is allowed to choose activities, and schedule health care and healthcare providers, that are consistent with his or her interests, values, assessments and plans of care, including: a. daily routine, such as sleeping and waking, eating, exercise and bathing schedules. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(u)(1)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to incorporate the recommendations from a resident's PASRR (Preadmission Screening and Resident Review) Level II determination and PASRR evaluation report for 1 of 1 resident reviewed for PASRR. (Resident 14)Findings include:The clinical record for Resident 14 was reviewed on 5/7/26 at 12:05 p.m. The resident's diagnoses included, but were not limited to: bipolar disorder (mental health condition that causes extreme, uncontrollable shifts in a person's mood), anxiety, and attention deficit disorder (neurodevelopmental disorder marked by persistent patterns of inattention, hyperactivity, and impulsivity). The physician's orders indicated Resident 14 was prescribed Aripiprazole (antipsychotic medication) Oral Tablet 5 MG tablet in the morning for bipolar disorder, effective 11/17/25, and Desvenlafaxine Succinate ER (antidepressant medication) Oral Tablet Extended Release 24 Hour 100 MG one tablet in the morning for bipolar disorder, effective 11/17/25. The PASRR Level II , dates 3/12/26, indicated she needed to be provided with mental health services that included individual therapy. The reasons for this support were she would benefit from mental health counseling to help cope with the symptoms of her bipolar disorder, and she needed medication monitoring with a psychiatrist/psychiatric nurse practitioner to make sure her medication was working well. There was no documentation in Resident 14's clinical record that indicated she received individual mental health therapy or medication monitoring with a psychiatrist/psychiatric nurse practitioner while in the facility. An interview was conducted with the Director of Nursing (DON) on 5/13/26 at 10:55 a.m., the DON indicated there was no verification that the recommendation for individual mental health therapy or medication monitoring with a psychiatrist/psychiatric nurse practitioner was addressed after the PASRR Level II dated 3/12/26. An interview was conducted with the Business Office Manager (BOM) on 5/13/26 at 11:13 a.m., the BOM indicated she scanned the PASRR Level IIs into residents' electronic health records, but she did not review them for recommendations. An interview was conducted with Resident 14 on 5/13/26 at 11:18 a.m., the resident indicated discussing her concerns in mental health counseling might help. The PASRR and Level of Care (LOC) admission policy was provided by the ED (Executive Director) on 5/13/26 at 11:53 a.m. It indicated, POST-admission REQUIREMENTS PASRR Compliance.Implement specialized services identified in Level II. DOCUMENTATION REQUIREMENTS The medical record must include: .Evidence of specialized services (if required) . RESPONSIBILITIES.Social Services: .Coordinate PASRR Level II process. Ensure follow-up on specialized services.

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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. The facility failed to accurately and complete document eternal feeding and flush documentations for 1 of 3 residents reviewed for documentation accuracy. (Resident 98) The clinical record for Resident 98 was reviewed on 5/11/2026 at 11:09 a.m. The resident's diagnoses included, but were not limited to, amyotrophic lateral sclerosis (progressive neurological disorder) and ventilator dependence. An annual Minimum Data Set (MDS) assessment, dated 2/14/2026, indicated Resident 98 was cognitively impaired, had verbal outbursts that affected others, did not have weight loss, and was dependent on tube feeding. The assessment indicated Resident 98 had impaired mobility in all four extremities, was dependent on staff for all activities of daily living, and did not take nutrition by mouth.A care plan, dated 6/5/2024 and revised on 2/25/2026, indicated Resident 98 had specialized needs. The interventions included, but were not limited to, providing specialized dietary management including nothing by mouth and providing supplemental nutrition via enteral feedings.A nutritional care plan, dated 6/14/2024 and revised on 2/25/2026, indicated Resident 98 was at risk for an alteration in nutrition due to the need for enteral feedings. The interventions included, but were not limited to, administering artificial nutrition support as ordered and administering flushes as ordered.A physician's order, dated 4/7/2026, indicated Resident 98 was to receive Diabetisource, 1.2 enteral feeding, at 55 mL(milliliters)/hour continuously, with a 10 mL/hour continuous water flush. The order indicated the feeding was to run through the G/J-tube and was related to unspecified severe protein-calorie malnutrition. A physician's order, dated 4/20/2026, indicated Resident 98's G/J-tube was to be flushed four times a day with 75 mL of water.Review of the May 2026 Medication and Treatment Administration Record indicated blank documentation for water flushes from May 1 at 6:00 p.m. until May 11 at 6:00 a.m. The resident's enteral feeding documentation was blank from May 1 during 2:00 p.m. to 10:00 p.m. shift until May 11 during 6:00 a.m. to 2:00 p.m. shift.During an observation, on 5/6/2026 at 1:05 p.m., Resident 98's tube feeding was observed as administering as ordered.During an interview with the Director of Nursing (DON), on 5/11/2026 at 1:38 p.m., the DON indicated there had been a system documentation error. The workflow for documenting enteral feedings had been changed to an electronic form the facility did not use. Staff had been completing shift checks on paper report sheets; however, those sheets were not retained as part of the resident's medical record. During an interview with the Administrator, on 5/13/2026 at 11:30 a.m., the Administrator indicated residents dependent on enteral feedings had not had any unexplained weight loss from 5/1/2026 through 5/11/2026. A policy entitled, Charting and Documentation, was provided by the Executive Director on 5/11/2026 at 2:57 PM. The policy indicated medication administrations, treatments and services performed should be documented in the medical record for each resident. 410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(1)410 IAC 16.2-3.1-50(a)(2)