STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00		F 0000		
	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00448890. Complaint IN00448890 - No deficiencies related to the allegations are cited. Survey dates: December 15, 16, 17, 18 and 19, 2024 Facility number: 000404 Provider number: 155512 AIM number: 100290810 Census Bed Type: SNF/NF: 74 RESIDENTIAL: 22 Total: 96 Census Payor Type: Medicare: 5 Medicaid: 65 Other: 26 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 23, 2024			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records Based on observation, interview, and record	F 0583	=”” p=””> =”” p=”>	01/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marie Wallace	Executive Director	01/14/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	review the facility failed to ensure privacy of health information for 2 of 18 residents reviewed (Resident 36 and Resident 72). Findings include: 1) During an observation on 12/15/24 at 10:32 AM, Resident 36 was viewed from the hallway sitting in her room in a wheelchair watching television. A catheter bag was observed attached to the wheelchair frame underneath the seat of the wheelchair. The catheter bag contained about 200 ml of yellow fluid. During an interview on 12/15/24 at 10:36 AM the Weekend Supervisor indicated urine in the catheter bag should not be visible from the hallway. Resident 36's record was reviewed on 12/16/24 at 2:52 PM. Diagnoses included obstructive and reflux uropathy, and encounter for attention to other artificial openings of the urinary tract. Resident 36's current Admission Minimum Data Set (MDS) dated 11/28/24 indicated their Basic Interview for Mental Status (BIMS) score was 6 (cognitively impaired). The MDS indicated Resident 36 needed maximal assistance with lower body activities of daily living. During an interview on 12/16/24 at 3:07 PM, the Director of Nursing (DON) indicated catheter bags should be maintained with a cover so contents cannot be viewed by any passersby. In an interview on 12/19/24 at 11:09 AM, the DON indicated the facility did not have a policy specifying how staff should keep contents of catheter bags from being seen by passersby.		=""> p=""> =""> p=""> =""> p=""> =""> p=""> =""> p=""> =""> p=""> =""> p=""> =""> p=""> Preparation and execution of this plan of correction does not constitute Ascension Living Sacred Heart Village's admission to or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of correction is prepared and executed pursuant to Ascension Living Sacred Heart Village's obligations under federal and state law. F 583 S/S=D Plan of Correction: 1. Corrective action for residents noted to have been affected by the deficient practice. Residents 36 and 72 were assessed by the DON on 1/3/2025 and showed no ill effects. A dignity cover was placed on the catheter bag on resident 36 on 12/15/24 and then the catheter was subsequently discontinued on 12/18/24. CNA 2 was counseled on maintaining resident privacy and confidentiality on 12/19/24. 2. How will the facility identify other residents having the potential to be affected	

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	2) During an observation on 12/15/24 at 12:16 PM, Resident 72 was seated in her wheelchair while Certified Nurse Aide (CNA) 2 was pushing her wheelchair out of the main dining room. CNA 2 called loudly to staff members in the assisted dining area across the hall; Resident 72 needed to go to the restroom and she did not know how to assist her. Residents, staff and a family member were all seated in the dining room, positioned to hear what was said. Resident 72's record was reviewed on 12/16/24 at 11:51 AM. Diagnoses included psychotic disorder with delusions due to known physiological conditions, rheumatoid arthritis, and need for assistance with personal care. Resident 72's current quarterly MDS indicated their Basic Interview for Mental Status (BIMS) score was 9 (cognitively impaired). The MDS indicated Resident 72 required supervision or touching assistance with toilet transfers, and partial/moderate assistance with toileting hygiene. Resident 72's current care plan, titled ...needs assistance with Activity of Daily Living (ADL) care, with a goal date of 2/3/24 indicated Resident 72 needed limited assistance with one person staff support for toileting activities. In an interview on 12/15/24 at 12:51 PM, Certified Nurse Aide (CNA) 2 indicated staff should not call across the room to communicate resident needs to one another. Staff should speak in low tones in a private area to communicate residents' personal needs to one another. In an interview on 12/16/24 at 3:07 PM, the DON indicated staff should go to a private area to		by the same deficient practice? All residents residing in the facility as of 1/2/2025 have the potential to be affected. Residents in the dining room on 1/3/25 were observed to ensure their dignity was maintained by the DON with no noted concerns. All residents with catheters were assessed to ensure privacy covers were in place. Care plans were reviewed and updated as needed. ="" p=""> 3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. All applicable staff were re-educated by DON or designee on promoting and maintaining resident dignity and quality of life-dignity policies on 1/6/2025 or prior to working their next scheduled shift. The policy and procedures promoting/maintaining resident dignity and quality of life- dignity have been reviewed by the IDT and are deemed appropriate. ="" p=""> 4. Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved. Under the direction of the Quality	

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	discuss resident needs and not reveal private information about residents in populated areas. A current policy, titled Confidentiality of Information, dated 12/2019, provided by the DON on 12/16/24 at 3:23 PM, indicated all resident information should be treated confidentially. 3-1(p)(5)		Assurance and Process Improvement (QAPI) Committee, the DON or designee will audit residents 3 x's weekly for 2 weeks, then weekly x 2 weeks, then monthly x 6 months to ensure dignity and privacy is consistently being maintained. • Audits will be submitted and reviewed by the QAPI committee for management of ongoing until 100% compliance determined by QAPI. The administrator is responsible for ensuring ongoing compliance. 5. Completion Date: 1/16/25 ="" p=""> ="" p=""> ="" p=""> br=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p="">	
F 0684 SS=D Bldg. 00	483.25 Quality of Care	F 0684	="" p="">Preparation and	01/16/2025

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	Based on interview and record review, the facility failed to ensure ongoing assessment for a change in condition for 1 of 4 residents reviewed (Resident 75) Findings include: Resident 75's record was reviewed 12/27/24 at 10:23 AM. Diagnoses included Cerebral infarction (stroke), diabetes, high blood pressure, and osteoarthritis, A review of progress notes indicated the following: Dated 10/1/24, Resident 75 was afebrile. Orders were obtained for a complete blood count and comprehensive metabolic panel. No reason for the tests or assessment of Resident 75's condition was documented. Dated 10/2/24, Resident 75 was placed on Robitussin. There was no documentation regarding breath sounds, or other condition of the resident. Dated 10/3/24, Resident 75 was placed on an antibiotic Invanz for urinary tract infection symptoms. The resident was afebrile, the urine color was yellow, and there were no complaints of pain on urination. There was no documentation regarding other symptoms of the infection, urine clarity, or presence of pain. Dated 10/4/24, No documentation regarding urinary symptoms was available for review. Dated 10/5/24, Resident 75 was afebrile, and her urine was yellow. Fluids were encouraged. Dated 10/6/24 at 9:21 PM, Resident 75 becomes very confused, the family was notified, urine characteristics were not documented. Dated 10/7/24 at 2:48 AM, Resident 75's urine was amber with sediment documented. Fluids were pushed. There was no documentation the family		execution of this plan of correction does not constitute Ascension Living Sacred Heart Village's admission to or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of correction is prepared and executed pursuant to Ascension Living Sacred Heart Village's obligations under federal and state law. ="" p="">F 684 S/S=D ="" p="">Plan of Correction: ="" p="">1. Corrective action for residents noted to have been affected by the deficient ="" p="">practice. ="" p="">Resident 75 was discharged from the facility on 10/12/24. ="" p="">2. How will the facility identify other residents having the potential to be affected ="" p="">by the same deficient practice? ="" p="">Other residents residing in the facility as of 1/2/2025 who are at risk for a Change in Condition have the potential to be affected. ="" p="">These residents were assessed for any change of condition in the last 14 days by the DON on 1/3/25 and showed no ill effect. Care plans were reviewed and updated as needed. ="" p="">3. The measures the facility will take or systems the	

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	or physician was notified of the change in the urine characteristics. Dated 10/7/24 at 10:22 PM, Resident 75 was eating only bites and pocketing food. The resident's confusion continued. The family was aware of the resident's condition, but there was no documentation the physician was notified. of the change in urine characteristics. Dated 10/8/24 at 10:20 AM, Resident 75's urine showed signs of blood. The note indicated the resident had been tugging on her catheter. The Nurse Practitioner was notified and the anchored catheter was discontinued. The notes indicated Resident 75's temperature was within normal limits. The note indicated the resident was confused, but did not indicate any other assessment of her condition. Dated 10/9/24 Resident 75's temperature was within normal limits. There was no documentation of her urine characteristics, but an increase in the resident's confusion was documented. Dated 10/10/24 indicated Resident 75 remained confused, did not urinate through the night. When toileted later in the morning, her urine was decreased amount, was amber and clear. Dated 10/11/24 indicated Resident 75 had increased confusion. but there was no documentation of urinary characteristics, color, clarity, or pain. Dated 10/12/24, Resident 75's temperature was 98.0. There was no other documentation regarding the resident's urinary characteristics. A physician's order, dated 10/12/24 at 3:30 PM, indicated to send Resident 75 to emergency room, related to low blood pressure and sepsis. In an interview on 12/17/24 at 11:15 AM, Licensed Practical Nurse (LPN) 8 indicated staff should be assessing the resident for changes in condition		facility will alter to ensure =”” p=””>that the problem will be corrected and will not recur. =”” p=””>All applicable staff were re-educated by DON or designee on Change in a resident's Condition or Status policy on 1/6/2025 or prior to working their next scheduled shift. The policy and procedure Change in a resident's Condition or Status has been reviewed by the IDT and is deemed appropriate. =”” p=””>4. Quality Assurance Plans to monitor facility compliance to make sure that =”” p=””>corrections are achieved. =”” p=””>Under the direction of the Quality Assurance and Process Improvement (QAPI) Committee, the DON or designee will audit all residents with changes of condition daily Monday through Friday x 2 weeks, then weekly x 2 weeks, then monthly x 6 months to ensure changes of condition have appropriate documentation in place. =”” p=””>Audits will be submitted and reviewed by the QAPI committee for management of 100% compliance determined by QAPI. =”” p=””>The administrator is responsible for ensuring ongoing compliance, =”” p=””>5. Completion Date: 1/16/25	

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	that indicate condition improvement or decline. 3.1-37		=”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””	

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F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, interview and record review, the facility failed to ensure functional and comfortable positioning for 1 of 3 residents reviewed (Resident 12). Findings include: On 12/15/24 at 12:35 PM, Resident 12 was observed sitting in an adjustable positioning wheelchair (Broda chair) in the dining room. Resident 12 was observed sitting upright with their head leaning forward. Resident 12's chin was observed to be approximately 1 inch from their chest. A staff member was observed lifting Resident 12's head by placing their hand on the resident's forehead. The staff member was observed placing a spoon in Resident 12's mouth while continuing to hold the resident's head up with their hand on the resident's forehead Resident 12's record was reviewed on 12/18/24 at 12:05 PM. Diagnoses included Alzheimer's, hypothyroidism, (underactive thyroid gland) muscle weakness and multiple sites of muscle contractures (tightening that can restrict movement). Resident 12's Quarterly Minimum Data Set, (MDS) dated 11/13/24, indicated the resident's Brief Interview for Mental Status (BIMS) score was not rated as the resident was seldom or never understood. The MDS indicated Resident 12 was dependent on staff for eating. The MDS indicated Resident 12 was dependent on staff for all position changes.	F 0688	=”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> Preparation and execution of this plan of correction does not constitute Ascension Living Sacred Heart Village's admission to or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of correction is prepared	01/16/2025

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	A physician order, dated 10/15/24, indicated Resident 12 could have a Broda chair for positioning and comfort. Resident 12's Care Plan, dated 10/29/24, indicated the resident required extensive or total assistance for all activities of daily living (ADLs). ADLs included eating, toileting, dressing, bathing and positioning. The target goal was for Resident 12 to have their ADL needs met through the next review period. Interventions included a total lift assistive device for transfers, a Broda chair for mobility and a hand roll to their left hand at night. Resident 12's Care Plan, dated 11/6/24, indicated the resident was at risk for further decline in range of motion due to having a contracture to their left hand. The target goal was for Resident 12 to have no further decline or complications to their left hand. Interventions included passive range of motion, hand roll to left hand at night, monitor and notify the nurse of any changes and the nurse was to inform Occupational Therapy (OT) of any issues. The Care Plan did not indicate Resident 12's head leaned forward. Resident 12's Care Plan, dated 118/24, indicated the resident was at risk for further decrease in all their joints due to reduced mobility and advanced dementia. The target goal was Resident 12 would not have a further decline of range of motion through the next review date unless the decline was clinically unavoidable. Interventions included passive range of motion to the upper and lower body, notify the nurse of changes and the nurse was to notify OT of changes. The Care Plan did not indicate Resident 12's head leaned forward. Resident 12's Care Plan, dated 10/29/24, indicated		and executed pursuant to Ascension Living Sacred Heart Village's obligations under federal and state law. F 688 S/S D Plan of Correction: 1. Corrective action for residents noted to have been affected by the deficient practice. Resident 12 was assessed by the DON on 1/3/2025 and showed no ill effects. A wedge cushion was implemented as recommended by OT. The wedge cushion was added to the nurse aide care sheets. Care plans have been reviewed and updated. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents residing in the facility as of 1/2/2025 who require use of positioning devices have the potential to be affected. These residents were assessed for use of positioning devices on 1/6/25 by the DON and showed no ill effect. All devices were in place as recommended by therapy and orders. Care plans were reviewed and updated as needed. ="" p="">> 3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.	

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	155512	A. BUILDING 00 B. WING	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

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	the resident was at risk for impaired nutrition. The target goal was for the resident to have nutritional needs met without significant weight changes through the next review. An intervention was a pureed diet. Interventions dated 11/1124 included providing supplements as ordered and weighing the resident monthly. An intervention dated 12/15/24 indicated Resident 12 needed fed by staff at mealtimes. The Care Plan did not indicate Resident 12's head leaned forward. On 12/18/24 at 12:25 PM, Resident 12 was observed sitting in their Broda chair in the dining room. Resident 12 was sitting upright in the Broda Chair. Resident 12's chin was approximately 1 inch from their chest. The staff member feeding Resident 12 encouraged Resident 12 to lift their head. Resident 12 lifted their head up a minimal amount. The staff member fed Resident 12 a spoonful while the staff member's head was lowered to the level of Resident 12. Resident 12 immediately lowered their head to the prior position of approximately 1 inch from their chest. In an interview on 12/18/24 at 12:41 PM, the Director of Nursing (DON) was made aware of Resident 12's head being manually lifted during lunch on 12/15/24. The DON indicated they were aware of Resident 12's Care Plan to notify OT for concerns. The DON indicated it was not unusual for Resident 12 to sit with their head leaning forward to their chest. The DON indicated Resident 12's head leaning forward was not a new occurrence. In an interview on 12/18/24 at 2:34 PM, the DON indicated Resident 12 had received OT services approximately 30 days ago. The DON indicated they believed OT had focused on Resident 12's head and neck positioning.		All applicable staff re-educated by DON or designee on repositioning devices and procedure on 1/6/2025 or prior to working their next scheduled shift. Therapy staff was re-educated on device recommendations and orders. Orders will be reviewed during clinical huddle and implemented as needed. Care plan and care guide will be reviewed and update The repositioning procedure has been reviewed by the IDT and is deemed appropriate. 4. Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved. Under the direction of the Quality Assurance and Process Improvement (QAPI) Committee, the DON or designee will audit residents with Positioning devices 3 times weekly x 2 weeks, then weekly x 2 weeks, then monthly x 6 months to ensure residents are positioned correctly. Audits will be submitted and reviewed by the QAPI committee for management of 100% compliance determined by QAPI. The administrator is responsible for ensuring ongoing compliance. 5. Completion Date: 1/16/2025<br="" p="">	

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Resident 12's therapy record was reviewed on 12/18/24 at 2:44 PM. Resident 12's OT start of care was 8/15/24. Resident 12's end of care was 9/24/24.

An OT Plan of Care, dated 8/15/24 at 8:08 PM, indicated OT was required to improve Broda chair positioning to reduce fall risk, prevent increased contractures and improve comfort. Resident 12's current level of function was contractures of the neck, the trunk, both arms and both legs. A short-term goal was for Resident 12 to achieve midline head and body alignment using head positioners and lateral support devices by 8/29/24. A long-term goal was for Resident 12 to achieve midline head and body alignment using head positioners and lateral support devices by 10/13/24.

An OT progress note dated 8/29/24 at 2:48 PM, indicated a short-term goal was for Resident 12 to achieve midline head and body alignment using head positioners and lateral support devices by 8/29/24. The clinical impression indicated Resident 12's seating had looked better with lateral support devices and staff had been educated for lateral support.

An OT progress note, dated 9/12/24 at 2:42 PM, indicated a short-term goal was for Resident 12 to achieve midline head and body alignment using head positioners and lateral support devices by 9/26/24. The clinical impression indicated Resident 12's midline had improved but was still leaning forward into flexion. The progress note indicated a wedge cushion was ordered.

An OT progress and discharge summary, dated 9/26/24 at 7:59 AM, indicated a long-term goal of Resident 12 12 to achieve midline head and body

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	alignment using head positioners and lateral support devices had been met. The clinical impression indicated the resident had improved their Broda chair positioning with the use of lateral supports and a high-profile step cushion. The summary indicated staff had been educated for adaptive equipment and Broda chair positioning. In an interview on12/18/24 at 3:15 PM, Certified Nurse Aide (CNA) 12 indicated they were not aware of Resident 12 having any postural positioning devices to assist with lifting their head. Resident 12's CNA worksheet was reviewed with CNA12. Resident 12's CNA worksheet indicated the nurse was to inform OT of any issues. The worksheet indicated Resident 12 was to have passive range of motion of their left hand prior to applying left hand splint, a mat at bedside while in bed, a total lift assistive device and a Broda chair. The CNA worksheet did not indicate Resident 12 had a positional device for their head and neck while in the Broda chair. On 12/19/24 at 10:01 AM, Resident 12 was observed in the beauty shop sitting upright in their Broda chair with their head leaning forward. Resident 12's feet were placed on a triangular shaped cushion. In an interview on 12/19/24 at 10:34 AM, the DON indicated Resident 12's Care Plan did not include the assistive equipment recommended by therapy. The DON indicated the aides were not aware of any assistive equipment recommended by therapy due to the recommendations not being on their CNA worksheets. A current facility policy, dated12/2017, provided by the DON on 12/19/24 at 11:10 AM, indicated			

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	155512	A. BUILDING 00 B. WING	12/19/2024

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	each resident's care plan should reflect their specific positioning needs. The policy indicated each resident would be placed be assisted into a comfortable position according to their individualized care plan. A current facility policy, dated 11/2019, provided by the DON on 12/19/24 at 11:10 AM, indicated residents who are unable to feed themselves would be fed by staff with attention to safety, comfort and dignity. 3.1-42(a)(1) 3.1-42(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview, and record review the facility failed to ensure sanitary handling of a catheter bag in 1 of 2 residents reviewed (Resident 36). Findings include: During an observation on 12/15/24 at 10:32 AM, Resident 36 was viewed from the hallway sitting in her room in a wheelchair watching television. A catheter bag was observed attached to the wheelchair frame underneath the seat of the wheelchair. The catheter bag contained about 200 ml of yellow fluid and was in contact with the floor. During an interview on 12/15/24 at 10:36 AM the Weekend Supervisor indicated urine in the catheter bag should be secured to the wheelchair keeping it from contacting the floor. She indicated contact with the floor could increase the risk of infection.	F 0690	=" p="">
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Preparation and execution of this plan of correction does not constitute Ascension Living Sacred Heart Village's admission to or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of correction is prepared	01/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Resident 36's record was reviewed on 12/16/24 at 2:52 PM. Diagnoses included obstructive and reflux uropathy, and encounter for attention to other artificial openings of the urinary tract. Resident 36's current Admission Minimum Data Set (MDS) dated 11/28/24 indicated their Basic Interview for Mental Status (BIMS) score was 6 (cognitively impaired). The MDS indicated Resident 36 needed maximal assistance with lower body activities of daily living. Resident 36's current care plan titled ...altered elimination related to uropathy ... indicated Resident 36, with a goal date of 2/24/25. Interventions included maintaining a closed drainage system. Physician orders dated 12/11/24 indicated Resident 36 should have a 16 french 10 ml foley catheter for obstructive uropathy. During an interview on 12/16/24 at 3:07 PM, the Director of Nursing (DON) indicated catheter bags should be maintained without contact with the floor. A current policy dated 12/2017 provided by the DON on 12/16/24 at 3:23 PM indicated staff should ensure the catheter tubing and bag were kept off the floor. 3.1-41(a)(2)		and executed pursuant to Ascension Living Sacred Heart Village's obligations under federal and state law. F 690 S/S D Plan of Correction: 1. Corrective action for residents noted to have been affected by the deficient practice. Resident 36 had her catheter D/C'd on 12/18/24. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Other residents residing in the facility as of 1/2/2025 that have catheters have the potential to be affected. These residents were assessed by the DON on 1/3/25 and showed no ill effect. Care plans were reviewed and updated as needed ="" p="">3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. Clinical staff were re-educated by DON or designee on catheter care procedure on 1/6/2025 or prior to working their next scheduled shift. The procedure- Catheter Care has	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			been reviewed by the IDT and is deemed appropriate. 4. Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved. ="" p="">"> Under the direction of the Quality Assurance and Process Improvement (QAPI) Committee, the DON or designee will audit residents with catheters 3 times weekly x 2 weeks, then weekly x 2 weeks, then monthly x 6 months to ensure catheters are positioned correctly. Audits will be submitted and reviewed by the QAPI committee for management of 100% compliance determined by QAPI. The administrator is responsible for ensuring ongoing compliance. 5. Completion Date: 1/16/2025 ="" p="">"> ="" p="">"> ="" p="">"> ="" p="">"> ="" p="">"> ="" p="">"> ="" p="">"> ="" p="">"> ="" p="">"> ="" p="">"> ="" p="">">	

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F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure safe, sanitary food storage and serving practices for 5 of 5 observations. Food prepared in the kitchen was consumed by 74 of 74 residents who lived in the facility. Findings include: During a continuous observation on 12/15/24 from 10:16 AM - 11:00 AM the following observations were made: A countertop had open slotted drains and a brown, murky liquid puddle under the countertop. The opened bag of french fries and bread were not dated in Freezer 1. Freezer 2 had whipped cream in a bag not labeled or dated. The whipped cream was unsealed and open to air. The opened bag of macaroni was not dated in the dry pantry. There was a package of swiss cheese, expired 11/2024, located in Refrigerator 1. 2 of 5 stacked metal pans had moisture between them. The stand mixer had dime sized, dry, yellow flaky material on the paddle. During a continuous observation from 11:34 AM-12:25 PM, Dietary Aide 4 donned gloves and	F 0812	="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> Preparation and execution of this plan of correction does not constitute Sacred Heart's admission to or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of correction is prepared and executed pursuant to Sacred Heart's obligations under federal and state law. F 812 - SS: F Plan of Correction: 1. Corrective action for residents noted to have been affected by the deficient practice. The Main Kitchen and all Unit Pantries were Deep Cleaned as of	01/16/2025

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	started distribution of food to resident plates. She touched brussel sprouts and bread with gloved hands. Dietary Aide 4 held clean bowls against her t-shirt, touched her shirt with her gloved hands and then resumed serving food. Dietary Aide 4 was observed using a pen to write on a meal ticket with her gloved hands and then resumed serving food. Dietary Aide 4 then scooped ice with a cup, and placed the cup onto the meal tray. Dietary Aide 4 did not perform hand hygiene or change gloves during the continuous observation. During the distribution of food, 3 plates from the clean stack were observed with small flecks of dried yellow particles. During an observation on 12/15/24 at 12:20 PM, Dietary Aide 11 assembled meal trays and covered dessert with plastic wrap. Her hands were gloved. Dietary Aide 11 knocked the plastic wrap box onto the floor. She then picked up the box with her gloved hands from the floor, resumed assembling the meal trays and covering desserts with the same plastic wrap. Dietary Aide 11 did not perform hand hygiene or change her gloves. In an interview, on 12/15/24 at 10:18 AM, Dietary Shift Supervisor 7 indicated the bread was to be used within one week. She indicated the mixer was now clean and ready to be used. She indicated there should not be dry yellow substance on the mixer. During an observation on 12/18/24 at 11:44 AM, Unit A's pantry freezer contained prepackaged meals with no date. In an interview on 12/18/24 at 11:44 AM, Certified Nurse Aide (CNA) 9 indicated the meals should		1/4/25: o The Countertop and slotted drains were cleaned 1/4/25. o The main kitchen, dry pantry, unit refrigerators, and resident refrigerators were checked for labels and dates, expired food was removed. The undated open macaroni was discarded. The pre-packaged undated food in Unit A refrigerator/ freezer was discarded. o Stacked pans were re-sanitized and separated to check for moisture before storing. o The stand mixer was deep cleaned on 1/4/25. o Plates, Utensils were removed and re-washed and sanitized 12/15/24 o The contaminated Plastic Wrap box was thrown out on 12/15/24. ="" p="">"> Reviewed the infection control log for the last 14 days. ="" p="">"> 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the issues cited. • The Dining Service Manager completed the Master Cleaning Schedule and Daily/Weekly Cleaning Tasks and Check Off List	

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	be labeled and dated. During an observation on 12/18/24 at 11:50 AM, Unit B's pantry refrigerator contained soup with an expiration date of 11/13/24. There were also black and brown particles and a popcorn kernel between the refrigerator and the floor. In an interview on 12/18/24 at 11:50 AM, Registered Nurse (RN) 10 indicated expired food should not be in the refrigerator. In an interview on 12/19/24 at 11:09 AM, the Director of Nursing (DON) indicated all 74 residents received food that was prepared in the facility kitchen. A current policy, dated 01/2023, titled "Food Preparation Area Safety and Sanitation," was provided by DON on 12/18/24 at 12:45 PM. The policy indicated "all counters and equipment should be cleaned and sanitized after each use." A current policy, dated 01/2023, titled "Food Purchasing and Storage," was provided by DON on 12/18/24 at 12:45 PM. The policy indicated "food storage areas shall be clean and dry at all times. Food must be date marked if it is prepared on site and refrigerated, or commercially processed after the original container is opened. Food shall be dated with the current date and be used or discarded per State Food Code Regulations." The policy also indicated "if potentially hazardous, ready-to-eat food is frozen, the food shall be dated with the current date and used or discarded per State Food Code Regulations." A current policy, dated 03/2023, titled "Foods Brought by Resident Representative(s)/Visitors		on January 3rd, 2025. 3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ="" p="">> Education was provided by the Director Dining services and/or designee to dining staff January 3rd-6th on: o Following the Master Cleaning Schedule. o Handwashing and Hygiene, including Glove Usage and Change (including cross contamination protocols). o Dishware and Utensil Handling. o Dishwashing Procedures, including Drying and Storage. Ice Handling, using the provided ice scoop, followed by proper storage. o Cleaning and Sanitation procedures. o Food Labeling and Storage. o Storage of Food Brought in By Visitors. ="" p="">> 4. Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved. Dining Service Manager and/or designee will check the compliance of cleaning schedule weekly.	

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	and Personal Refrigerators," was provided by DON on 12/18/24 at 12:45 PM. The policy indicated "perishable foods brought into the community and stored in the kitchenette refrigerators or the resident's room shall be clearly marked with ... 2. food items labeled with an expiration date shall be marked with the date opened and stored until the expiration date." The policy also indicated the kitchenette refrigerators shall be monitored by the dining staff for outdated/expired food. A current policy, dated 08/2024, titled "Hand Hygiene," was provided by DON on 12/18/24 at 12:45 PM. The policy indicated hand hygiene should be preformed before and after handling food and the use of gloves did not replace hand hygiene. 3.1-21(i)(3)		Dining Service Manager and /or designee will conduct a monthly kitchen sanitation audit to ensure kitchen and unit refrigerators are all maintained in a clean and organized condition. Dining Service Manager and/or designee will monitor Hand Hygiene/Glove Usage, Dishwashing Procedures, Ice Handling, Cleaning and Sanitation, Food Labeling and Storage, and Dishware and Utensil Handling weekly with Corrective Action Log for 6 months. Dining Service Manager will report the results of monthly kitchen safety and sanitation audits to the community's QA committee monthly until deemed 100 % compliant by QAPI. The administrator is responsible for ongoing compliance. 5. Completion Date: 1/16/2025 ="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p=""	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This included a Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00448890. Survey dates: December 15, 16, 17, 18 and 19, 2024. Facility number: 000404 Residential Census: 22 Ascension Living Sacred Heart Village was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed December 23, 2024	R 0000		