STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155512	A. BUILDING -- B. WING	02/05/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/05/25 Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810 At this Emergency Preparedness survey, Ascension Living Sacred Heart Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 133 certified beds. At the time of the survey, the census was 76. Quality Review completed on 02/07/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification (LSC) and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/05/25 Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810 At this LSC survey, Ascension Living Sacred	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marie Wallace	Executive Director	02/20/2025

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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	Heart Village 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, LSC, Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detector in the resident rooms. the facility is partly protected by a type II EES 200 kW diesel powered generator. The facility has a capacity of 133 and had a census of 76 at the time of this survey. Quality Review completed on 02/07/25			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities (#1.) Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchens. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. (#2.) Based on observation and interview, the facility failed to properly install and maintain equipment protected by 1 of 1 kitchen hood extinguishing systems. LSC 9.2.3 states cooking equipment shall be in accordance with NFPA 96. NFPA 96 section 12.1.2.2 states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by	K 0324	K324 S/S=E Life Safety Plan of Correction Ascension Living Sacred Heart Village SURVEY EXIT DATE: 2/5/2025 Life Safety - Plan of Correction: 1. Corrective action for residents noted to have been affected by the deficient practice. No residents were noted in the deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents residing in the facility have potential to be affected. 3. The measures the facility will take or systems the facility will alter to ensure that the	02/20/2025

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	the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system, unless such installations are approved existing installations, which shall be permitted to be continued in service, and have an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Section 10.1.2 states cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. The deficient practices affect staff in the kitchen and 40 residents in the main dining room. Findings include: (#1.) Based on observation with the Maintenance Director and the Maintenance-Tech on 02/05/25 at 11:16 a.m., the kitchen was provided with a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, a dietary staff member was asked how to activate the hood suppression system if there was a grease fire underneath the hood. The dietary staff member stated he did not know where the pull station to activate the suppression system was located. The Maintenance Director acknowledged the Cooks response and stated staff will need to be trained on the proper procedures for extinguishing a grease fire on the cooking equipment. (#2.) Based on observation with the Maintenance Director and the Maintenance-Tech on 02/05/25 at 11:18 a.m., the cooking equipment in the main kitchen was covered by the fire suppression system, but the kitchen was not provided with an		problem will be corrected and not recur. Dietary and Maintenance staff have been educated by Dietary Manager and Facilities Director on or by 2/20/2025 or prior to working their next scheduled shift on: cooking appliances are not to be moved from designated space / and are to always be returned to approved location, all campus dietary staff know where and how to access the pull station for fire suppression The Training has been reviewed by the IDT and is deemed appropriate. TELS work order #4692 has been completed. Pictures submitted. All new hires and current staff will be or have been educated with audits x 6 months 4. Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. Under the direction of the Quality Assurance and Process Improvement (QAPI) Committee, the Dietary Manager or designee will audit x times each [week/month] x 6 months to ensure; cooking appliances are not moved from designated space / and are returned to approved location, staff know where and how to access the pull station for fire suppression. Audits will be submitted and reviewed by the QAPI committee for management of ongoing compliance and will continue x 6 months minimum or	

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	approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Also, the flat top grill was not fully under the hood and was not fully covered by the suppression system. Based on an interview during observation, the Maintenance Director agreed the grill was not properly located under the hood, and the kitchen was not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. The findings were reviewed with the Administrator, Maintenance Director, and the Maintenance-Tech during the exit conference. 3.1-19(b)		until otherwise determined by QAPI, The administrator is responsible for ensuring ongoing compliance. 5. Completion Date: 2/20/2025	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 1 of 1 pantries in the Saint Clare wing open to the corridor were provided with electrically supervised automatic smoke detection system. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be permitted to be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect staff and up to 20 residents in one smoke compartment.	K 0361	K361 s/S=E Life Safety - Plan of Correction: 1. Corrective action for residents noted to have been affected by the deficient practice. No residents were noted in the deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents residing in the facility have the potential to be affected. 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. TELS work order #4678 - completed. Pictures - attached.	02/20/2025

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	Findings include: Based on observations with the Maintenance Director and the Maintenance-Tech on 02/05/25 at 11:30 a.m., the Saint Clare pantry contained a pass-through window measuring 45"x29" therefore making the pantry open to the corridor. When inspected the pantry did not contain an electrically supervised automatic smoke detection device. Based on interview at the time of observation, the Maintenance Director provided the measurements of the pass-through window, agreed the pantry was open to the corridor, and did not contain an electrically supervised automatic smoke detection device. The findings were reviewed with the Administrator, Maintenance Director, and the Maintenance-Tech during the exit conference. 3.1-19(b)		Vendor invoice - attached. All smoke detectors will be inspected for proper performance via TELS performance system audits. 4. Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. Under the direction of the Quality Assurance and Process Improvement (QAPI) Committee, the Facility Director or designee will audit all smoke detectors will be Inspected for proper performance with TELS audits x 6 months • Audits will be submitted and reviewed by the QAPI committee for management of ongoing compliance and will continue x 6 months minimum or until otherwise determined by QAPI. The administrator is responsible for ensuring ongoing compliance. 5. Completion Date: 2/20/2025	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 1 therapy gym corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 10 residents in the therapy gym. Findings include: Based on observations with the Maintenance	K 0363	K363 S/S=E Life Safety - Plan of Correction: 1. Corrective action for residents noted to have been affected by the deficient practice. No specific residents were noted in the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents residing in the facility have the potential to be affected.	02/20/2025

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	Director and the Maintenance-Tech on 02/05/25 at 12:23 p.m., the double set of corridor doors to the therapy gym did not latch into the frame when tested due to the latch catches being removed. Based on interview at the time of observation, the Maintenance Director stated the corridor doors would not latch into the door frame and would install new latch catches. The findings were reviewed with the Administrator, Maintenance Director, and the Maintenance-Tech during the exit conference. 3.1-19(b)		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. TELS work order #4663 - completed. Vendor Invoice -submitted. Pictures -attached. • Therapy Gym corridor doors will be inspected for proper performance with TELS audits x 6 months 4. Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. Under the direction of the Quality Assurance and Process Improvement (QAPI) Committee, the Facility Director or designee will audit that Therapy Gym corridor doors will be inspected for proper performance with TELS audits x 6 months Audits will be submitted. and reviewed by the QAPI committee for management of ongoing compliance and will continue x 6 months minimum or until otherwise determined by QAPI. The administrator is responsible for ensuring ongoing compliance. 5. Completion Date: 2/20/2025	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 1 ground fault circuit interrupter (GFCI) in the Saint Francis break room was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at	K 0511	K511 S/S E Life Safety - Plan of Correction: 1. Corrective action for residents noted to have been affected by the deficient practice. No specific residents were noted	02/20/2025

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	210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director and the Maintenance-Tech on 02/05/25 at 11:43 a.m., when the GFCI electric receptacle in the Saint Francis break room was tested with a GFCI tester, the GFCI receptacle failed to trip and did not break the electrical circuit. Based on an interview at the time of observation, the Maintenance Director agreed the GFCI electric receptacle did not properly work when tested. The findings were reviewed with the Administrator, Maintenance Director, and the Maintenance-Tech during the exit conference. 3.1-19(b)		in the deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents residing in the facility have the potential to be affected. 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. TELS work order #4584 - completed. Pictures of repair -submitted. GCFI will be inspected for proper installation and performance with TELS audits x 6 months 4. Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. Under the direction of the Quality Assurance and Process Improvement (QAPI) Committee, the Facility Director or designee will audit x 6 months via TELS that the GCFI on St. Francis break room is monitored to perform according to industry standards. Audits will be submitted and reviewed by the QAPI committee for management of ongoing compliance and will continue x 6 months minimum or until otherwise determined by QAPI. The administrator is responsible for ensuring ongoing compliance. 5. Completion Date: 2/20/2025	
K 0754 SS=E	NFPA 101 Soiled Linen and Trash Containers			

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Bldg. 01	Based on observation and interview, the facility failed to ensure trash receptacles in 1 of 3 corridors were maintained in accordance with LSC 19.7.5.7. This deficient practice could affect staff and up to 20 residents in the Hutzel-hall. Findings include: Based on observations with the Maintenance Director and the Maintenance-Tech on 02/05/25 at 12:01 p.m., there were three 33-gallon soiled linen/trash barrels within 8 feet of each other on the Hutzel-hall. Based on interview at the time of observation, the Maintenance Director stated there were three 33-gallon barrels of soiled linen/trash totaling 99 gallons in a 64 square foot area on the Hutzel-hall. The findings were reviewed with the Administrator, Maintenance Director, and the Maintenance-Tech during the exit conference. 3.1-19(b)	K 0754	K754 S/S=E Life Safety - Plan of Correction: 1. Corrective action for residents noted to have been affected by the deficient practice. No specific residents were noted in the deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents residing in the facility have the potential to be affected. 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. EVS and Clinical Staff have been educated by Facilities Director and DON on 2/20/2025 or prior to working their next scheduled shift on: ensuring the trash receptacles are maintained both with location and weight capability. (In-service sign - in sheet attached). TELS work order # 4690- completed. Pictures of new identifier placements - attached. The Training has been reviewed by the IDT and is deemed appropriate Trash receptacles on the units will be inspected for proper placement and capacity audits x 6 months - audit sheet attached. 4. Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. Under the direction of the Quality Assurance and Process Improvement (QAPI)	02/20/2025

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			Committee, the Facility Director or designee will audit x 6 months to ensure: Trash receptacles on the units will be inspected for proper placement and capacity audits (audit sheet attached) Audits will be submitted and reviewed by the QAPI committee for management of ongoing compliance and will continue x 6 months minimum or until otherwise determined by QAPI. The administrator is responsible for ensuring ongoing compliance. Completion Date: 2/20/2025	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 20 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director and the Maintenance-Tech on 02/05/25 at 11:00 a.m., the oxygen storage/transfer room contained large liquid oxygen tanks. There was a vent that led to the outside but there was no pull of air from the vent. Based on interview at the time of observation, the Maintenance Director could	K 0927	K927 S/S=E Life Safety - Plan of Correction: 1. Corrective action for residents noted to have been affected by the deficient practice. No specific residents were noted in the deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents residing in the facility have the potential to be affected. 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. TELS work order #4655 - completed. Ensuring that the air pull from Oxygen room to the outside is consistently functioning appropriately with TELS audits x 6 months 4. Quality Assurance	02/20/2025

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	not locate the fan motor and stated there was no air pulling from the room to the outside. The findings were reviewed with the Administrator, Maintenance Director, and the Maintenance-Tech during the exit conference. 3.1-19(b)		Plans to monitor facility compliance to make sure that corrections are achieved and permanent. Under the direction of the Quality Assurance and Process Improvement (QAPI) Committee, the Facility Director or designee will audit to Ensuring that the air pull from Oxygen room to the outside is consistently functioning appropriately with TELS audits x 6 months Audits will be submitted and reviewed by the QAPI committee for management of ongoing compliance and will continue x 6 months minimum or until otherwise determined by QAPI. The administrator is responsible for ensuring ongoing compliance. 5. Completion Date: 2/20/2025	