		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155512	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/05/2025	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ASCENS	ION LIVING SACRE	ED HEART VILLAGE			, IN 46710		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	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		E 0000				
	Quality Review com	npleted on 02/07/25					
K 0000							
Bldg. 01	Licensure Survey w Department of Healt 483.90(a). Survey Date: 02/05 Facility Number: 00 Provider Number: 1 AIM Number: 1002	00404 155512	K 00	000			

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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02/25/2025 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 02/05/2025 155512 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 515 N MAIN ST ASCENSION LIVING SACRED HEART VILLAGE **AVILLA. IN 46710** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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 **NFPA 101** SS=E Cooking Facilities Bldg. 01 (#1.) Based on observation and interview, the K 0324 K324 S/S=E Life Safety Plan of 02/20/2025 facility failed to ensure staff were instructed in the Correction Ascension Living use of the UL 300 hood system in 1 of 1 Kitchens. Sacred Heart Village SURVEY NFPA 96, 11.1.4 states instructions for manually EXIT DATE: 2/5/2025 Life Safety operating the fire extinguishing system shall be Plan of Correction: 1. Corrective posted conspicuously in the kitchen and shall be action for residents noted to have reviewed with employees by management. been affected by the deficient practice. No residents were noted (#2.) Based on observation and interview, the in the deficient practice. 2. How facility failed to properly install and maintain will the facility identify other equipment protected by 1 of 1 kitchen hood residents having the potential to extinguishing systems. LSC 9.2.3 states cooking be affected by the same deficient equipment shall be in accordance with NFPA 96. practice? All residents residing in

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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

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the facility have potential to be

affected. 3. The measures the

facility will take or systems the

facility will alter to ensure that the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION A. BUILDING 01 COMPLETED 155512 B. WING 02/05/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 515 N MAIN ST ASCENSION LIVING SACRED HEART VILLAGE **AVILLA. IN 46710** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the system installer or servicing agent, unless problem will be corrected and not otherwise allowed by the design of the fire recur. Dietary and Maintenance extinguishing system, unless such installations staff have been educated by are approved existing installations, which shall be Dietary Manager and Facilities permitted to be continued in service, and have an Director on or by 2/20/2025 or approved method that would ensure that the prior to working their next appliances were returned to an approved design scheduled shift on: cooking location after they had been moved for appliances are not to be moved maintenance and cleaning. Section 10.1.2 states from designated space / and are cooking equipment that produces grease-laden to always be returned to approved vapors and that might be a source of ignition of location, all campus dietary staff grease in the hood, grease removal device, or duct know where and how to access shall be protected by fire-extinguishing the pull station for fire equipment. suppression The Training has been reviewed by the IDT and is The deficient practices affect staff in the kitchen deemed appropriate. TELS work and 40 residents in the main dining room. order #4692 has been completed. Pictures submitted. All new hires Findings include: and current staff will be or have been educated with audits x 6 (#1.) Based on observation with the Maintenance months 4. Quality Assurance Director and the Maintenance-Tech on 02/05/25 at Plans to monitor facility 11:16 a.m., the kitchen was provided with a UL 300 compliance to make sure that hood system and a K-class fire extinguisher with corrections are achieved and posted instructions. Based on interview, a dietary permanent. Under the direction of staff member was asked how to activate the hood the Quality Assurance and suppression system if there was a grease fire Process Improvement (QAPI) underneath the hood. The dietary staff member Committee, the Dietary Manager stated he did not know where the pull station to or designee will audit x times each activate the suppression system was located. The [week/month] x 6 months to Maintenance Director acknowledged the Cooks ensure; cooking appliances are response and stated staff will need to be trained not moved from designated space on the proper procedures for extinguishing a / and are returned to approved grease fire on the cooking equipment. location, staff know where and how to access the pull station for (#2.) Based on observation with the Maintenance fire suppression. Audits will be Director and the Maintenance-Tech on 02/05/25 at submitted and reviewed by the 11:18 a.m., the cooking equipment in the main QAPI committee for management kitchen was covered by the fire suppression of ongoing compliance and will system, but the kitchen was not provided with an continue x 6 months minimum or

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUIL		<u>01</u>	COMPLETED		
155512		B. WING	<u> </u>		02/05/	2025		
NAME OF PROVIDER OR SUPPLIER ASCENSION LIVING SACRED HEART VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 515 N MAIN ST AVILLA, IN 46710						
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	``			TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE	
K 0361	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 ongoi compliance. 5. Completion Da 2/20/2025	_		
SS=E Bldg. 01	Based on observation failed to ensure 1 of wing open to the confidence of electrically supervisives. LSC 19.3.6 than patient sleeping hazardous areas shat the corridor and unlied The space and corridor to in the same small protected by an electromagnetic of the space of sprinklers, and (c) Taccess to required expressions.	on and interview, the facility I pantries in the Saint Clare rridor were provided with sed automatic smoke detection I(7) states that spaces other g rooms, treatment rooms, and Il be permitted to be open to imited in area, provided: (a) dors which the space opens tooke compartment are extrically supervised automatic stem in accordance with 19.3.4, is protected by an automatic The space does not to obstruct xits. This deficient practice d up to 20 residents in one	K 036	51	K361 s/S=E Life Safety - Plan Correction: 1. Corrective action residents noted to have been affected by the deficient practi No residents were noted in the deficient practice. 2. How will facility identify other residents having the potential to be affect by the same deficient practice 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 retain the problem.	n for ce. the tted All ded. iiii	02/20/2025	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155512		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/05/2025			
	PROVIDER OR SUPPLIER	ED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP COD 515 N MAIN ST AVILLA, IN 46710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	Director and the Ma 11:30 a.m., the Sair pass-through windo therefore making th When inspected the electrically supervis device. Based on in observation, the Ma the measurements of agreed the pantry w did not contain an e automatic smoke de The findings were r Administrator, Main			Vendor invoice - attached. Al smoke detectors will be inspet for proper performance via T performance system audits. A Quality Assurance Plans to monitor facility compliance to make sure that corrections a achieved and permanent. Unthe direction of the Quality Assurance and Process Improvement (QAPI) Commit the Facility Director or design will audit all smoke detectors be Inspected for proper performance with TELS audit months • Audits will be submand reviewed by the QAPI committee for management ongoing compliance and will continue x 6 months minimur until otherwise determined by QAPI. The administrator is responsible for ensuring ong compliance. 5. Completion D 2/20/2025	ected ELS 4. re der ttee, nee will ts x 6 itted of m or		
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors						
, <u> </u>	failed to ensure 1 of were provided with the door closed, had latching and would This deficient pract the therapy gym. Findings include:	on and interview, the facility f 1 therapy gym corridor doors a means suitable for keeping I no impediment to closing, resist the passage of smoke. ice could affect 10 residents in	K 0363	K363 S/S=E Life Safety - Plate Correction: 1. Corrective actions action residents noted to have been affected by the deficient practice. No specific residents were not in the deficient practice. How the facility identify other residenty the potential to be affected by the same deficient practic residents residing in the facility have the potential to be affected.	on for tice. oted will lents ected e? All		

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STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155512	B. W	B. WING			02/05/2025	
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIER	₹						
ASCENS	SION LIVING SACE	ED HEART VILLAGE		515 N MAIN ST AVILLA, IN 46710				
ASCENS	OION LIVING SACK	ED HEART VILLAGE		AVILLA	., 111 407 10			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		aintenance-Tech on 02/05/25 at			3. The measures the facility w			
	_	ble set of corridor doors to the			take or systems the facility will			
		t latch into the frame when			alter to ensure that the probler	m		
		ch catches being removed.			will be corrected and will not re	ecur.		
		at the time of observation, the			TELS work order #4663 -			
		tor stated the corridor doors			completed. Vendor Invoice			
		the door frame and would			-submitted. Pictures -attached			
	install new latch car	tches.			Therapy Gym corridor doors w	/ill		
					be inspected for proper			
	The findings were r				performance with TELS audits	x 6		
	· · · · · · · · · · · · · · · · · · ·	ntenance Director, and the			months 4. Quality Assurance			
	Maintenance-Tech	during the exit conference.			Plans to monitor facility			
	2.1.10(1.)				compliance to make sure			
	3.1-19(b)				that corrections are achieved a			
					permanent. Under the directio	n ot		
					the Quality Assurance and			
					Process Improvement (QAPI)			
					Committee, the Facility Director			
					designee will audit that Therap	у		
					Gym corridor doors will be inspected for proper performal	200		
					with TELS audits x 6 months	iice		
					Audits will be submitted. and			
					reviewed by the QAPI commit	too		
					for management of ongoing	iee		
					compliance and will continue	<i>r</i> 6		
					months minimum or until	. 0		
					otherwise determined by QAP	ı		
					The administrator is responsib			
					for ensuring ongoing complian			
					5. Completion Date: 2/20/2025			
K 0511	NFPA 101							
SS=E	Utilities - Gas and	Electric						
Bldg. 01								
	Based on observation	on and interview, the facility	K 0	511	K511 S/S E Life Safety - Plan	of	02/20/2025	
	failed to ensure 1 of	f 1 ground fault circuit			Correction: 1. Corrective action			
	interrupter (GFCI)	in the Saint Francis break room			residents noted to have been			
	was properly maint	ained for protection against			affected by the deficient practi	ce.		
	electric shock. NFI	PA 70, NEC 2011 Edition at			No specific residents were not			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155512	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COMP	E SURVEY PLETED 5/2025
	PROVIDER OR SUPPLIES	R RED HEART VILLAGE	515 N	ADDRESS, CITY, STATE, ZIP CO MAIN ST A, IN 46710)D	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF 210.8 Ground-Faul for Personnel, state circuit-interruption provided as require practice could affect compartment. Findings include: Based on observati Director and the M 11:43 a.m., when the Saint Francis break tester, the GFCI recent for the state of the electric interview at the time Maintenance Director receptacle did not put the findings were administrator, Main	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION It Circuit-Interrupter Protection rs, ground-fault for personnel shall be rd in 210.8. This deficient ret 20 residents in one smoke ons with the Maintenance aintenance-Tech on 02/05/25 at the GFCI electric receptacle in the re room was tested with a GFCI reptacle failed to trip and did rical circuit. Based on an the of observation, the tor agreed the GFCI electric rooperly work when tested.	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY) in the deficient practice, will the facility identify o residents having the pope be affected by the same practice? All residents in the facility have the pote affected. 3. The measur facility will take or syste facility will alter to ensur problem will be corrected not recur. TELS work or completed. Pictures of submitted. GCFI will be for proper installation and performance with TELS months 4. Quality Assur Plans to monitor facility compliance to make sur corrections are achieved permanent. Under the cuthe Quality Assurance at Process Improvement (Committee, the Facility designee will audit x 6 in TELS that the GCFI on break room is monitored perform according to indicate the submitted and reviewed QAPI committee for ma of ongoing compliance accontinue x 6 months mit until otherwise determined QAPI. The administrator responsible for ensuring compliance. 5. Complete 2/20/2025	2. How ther tential to be deficient residing in rential to be rest the rest the rethat t	(X5) COMPLETION DATE
K 0754 SS=E	NFPA 101 Soiled Linen and	Trash Containers				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPL	ETED
155512		155512	B. WING			02/05/2025	
				_	_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
4005110					MAIN ST		
ASCENS	ION LIVING SACRE	ED HEART VILLAGE		AVILLA	, IN 46710		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
Bldg. 01							
Ŭ	Based on observation	on and interview, the facility	K 0	754	K754 S/S=E Life Safety - Plan	of	02/20/2025
		h receptacles in 1 of 3	110	731	Correction: 1. Corrective action		02/20/2023
		stained in accordance with LSC			residents noted to have been		
		ent practice could affect staff			affected by the deficient practic	^_	
		its in the Hutzel-hall.			No specific residents were not		
	and up to 20 residen	no in the franzer nam.			in the deficient practice. 2. How		
	Findings include:				will the facility identify other	·v	
	i maniga metude.				residents having the potential	to	
	Dagad on absorpatio	ons with the Maintenance					
		sintenance-Tech on 02/05/25 at			be affected by the same defici-		
		ere three 33-gallon soiled			practice. All residents residing		
		vithin 8 feet of each other on			the facility have the potential to		
					affected. 3. The measures the		
		ed on interview at the time of			facility will take or systems the		
		intenance Director stated			facility will alter to ensure that		
		gallon barrels of soiled			problem will be corrected and		
		99 gallons in a 64 square foot	not recur. EVS and Clinical St				
	area on the Hutzel-h	nall.			have been educated by Facilit		
					Director and DON on 2/20/202	5 or	
	The findings were re				prior to working their next		
		ntenance Director, and the			scheduled shift on: ensuring th		
	Maintenance-Tech	during the exit conference.			trash receptacles are maintain	ed	
					both with location and weight		
	3.1-19(b)				capability. (In-service sign - in		
					sheet attached). TELS work or		
					# 4690- completed. Pictures of	f	
					new identifier placements -		
					attached. The Training has be	en	
					reviewed by the IDT and is		
					deemed appropriate Trash		
					receptacles on the units will be	;	
					inspected for proper placemen	t	
					and capacity audits x 6 months	s -	
					audit sheet attached. 4. Qualit	y	
					Assurance Plans to monitor		
					facility compliance to make su	re	
					that corrections are achieved a		
					permanent. Under the direction	n of	
					the Quality Assurance and		
					Process Improvement (QAPI)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155512	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/05/2025		
NAME OF PROVIDER OR SUPPLIER ASCENSION LIVING SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 515 N MAIN ST AVILLA, IN 46710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Table Based on observation failed to ensure 1 of where oxygen transprovided with proper ventilation. NFPA requires oxygen transprovided with proper ventilation. NFPA requires oxygen transprovided with proper ventilation. NFPA requires mechanically ventilated requires mechanically ventilated requires mechanically ventilated to one smoke comparts. Findings include: Based on observation Director and the Mathematical transport of the contained large liquity ventilated to the contained large liquity ventilated	Transfilling Cylinders on and interview, the facility 1 oxygen storage rooms ferring takes place, was erly working mechanical 99 2012 edition, 11.5.2.3.1 (2) asfilling rooms to be ated. Section 9.3.7.5.3.1 I exhaust to maintain a the space continuously. This buld affect up to 20 residents in	K 0927	Committee, the Facility Director designee will audit x 6 months ensure: Trash receptacles on units will be inspected for propplacement and capacity audits (audit sheet attached) Audits who be submitted and reviewed by QAPI committee for managem of ongoing compliance and will continue x 6 months minimum until otherwise determined by QAPI. The administrator is responsible for ensuring ongoing compliance. Completion Date: 2/20/2025 K927 S/S=E Life Safety - Plant Correction: 1. Corrective action residents noted to have been affected by the deficient practice. No specific residents were not in the deficient practice. 2. How will the facility identify other residents having the potential be affected by the same deficing practice. All residents residing the facility have the potential to affected. 3. The measures the facility will alter to ensure that problem will be corrected and not recur. TELS work order #4 - completed. Ensuring that the pull from Oxygen room to the outside is consistently function appropriately with TELS audits affected with TELS audits appropriately with TELS audits appropriately with TELS audits	s to the per s will the nent ll or ing the ted w to tent in oo be the will l655 e air	02/20/2025	

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of observation, the Maintenance Director could

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months 4. Quality Assurance

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155512		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 02/05/2025				
NAME OF PROVIDER OR SUPPLIER ASCENSION LIVING SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 515 N MAIN ST AVILLA, IN 46710					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	air pulling from the The findings were i Administrator, Mai	room to the outside. reviewed with the ntenance Director, and the during the exit conference.			Plans to monitor facility compliance to make sure that corrections are achieved and permanent. Under the directio the Quality Assurance and Process Improvement (QAPI) Committee, the Facility Director or designee will audit Ensuring that the air pull from Oxygen room to the outside is consistently functioning appropriately with TELS audits months Audits will be submitted and reviewed by the QAPI committee for management of ongoing compliance and will continue x 6 months minimum until otherwise determined by QAPI. The administrator is responsible for ensuring ongo compliance. 5. Completion Dai 2/20/2025	n of / to s x 6 ed or		

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