PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155512	A. BUILDING B. WING	00	COMPLETED 01/08/2024
		.55512	<u> </u>	ADDDECC CITY CTATE TIP COD	5 1/50/2021
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD MAIN ST	
ASCENS	SION LIVING SACR	ED HEART VILLAGE		, IN 46710	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
F 0000	REGULATORY OR	CLSC IDENTIFFING INFORMATION	TAG		DATE
Bldg. 00	This visit was for a	Recertification and State	F 0000		
	Licensure Survey.	This visit included a State are Survey. This visit included	1 0000		
		Residential Complaint			
	Survey dates: Janua 2024	ary 2, 3, 4, 5 and January 8,			
	Facility number:	000404			
	Provider number:				
	AIM number:	100290810			
	Census Bed Type: SNF/NF: 71				
	Residential: 28				
	Total: 99				
	Census Payor Type	:			
	Medicare: 1				
	Medicaid: 80				
	Other: 18 Total: 99				
	10tai. 99				
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.			
	Quality review com	upleted January 10, 2024			
F 0583 SS=D	483.10(h)(1)-(3)(i)	(ii) Confidentiality of Records			
Bldg. 00		y and Confidentiality.			
		a right to personal privacy			
		of his or her personal and			
	medical records.				
	§483.10(h)(l) Pers	sonal privacy includes			
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE
Jennifer Be	eck		RN, DON	1	01/23/2024

Any defiency statement 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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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155512	B. WI	NG		01/08/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			MAIN ST		
ASCENS	SION LIVING SACR	ED HEART VILLAGE			, IN 46710		
				, (VILL) (, 114 107 10		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL]	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	· ·	medical treatment, written					
	· ·	mmunications, personal					
		neetings of family and					
		out this does not require the					
		a private room for each					
	resident.						
	• ',',	e facility must respect the					
		personal privacy, including					
	the right to privacy in his or her oral (that is, spoken), written, and electronic						
	communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means						
	other than a posta	_					
	outer than a poot	21 301 VI90.					
	§483.10(h)(3) The	e resident has a right to					
	- , , , ,	lential personal and medical					
	records.	·					
	(i) The resident ha	as the right to refuse the					
		al and medical records					
	except as provide	d at §483.70(i)(2) or other					
	applicable federal	or state laws.					
	(ii) The facility mu	st allow representatives of					
	the Office of the S	State Long-Term Care					
	Ombudsman to ex	xamine a resident's					
	medical, social, a	nd administrative records in					
	accordance with S						
		on, interview, and record	F 05	83	="" p="">		01/26/2024
	1	failed to ensure privacy was					
		24 residents reviewed			Preparation and execution of t	his	
	(Resident 24, and R	Resident 32).			plan of correction does not		
					constitute Sacred Heart's		
	Findings include:				admission to or agreement wit		
	1, 5				the facts alleged or conclusion	ıs	
	, .	vation and interview on 1/2/24			set forth in the Statement of		
		ent 24's catheter bag partially			Deficiencies, and such liability		
	filled with yellow l	iquid was visible from his			specifically denied. The plan o	î	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WA2K11 Facility ID: 000404

If continuation sheet Page 2 of 40

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155512	B. W	NG		01/08/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			MAIN ST		
ASCENS	ION LIVING SACR	ED HEART VILLAGE			, IN 46710		
					, 114 107 10		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		EGULATORY OR LSC IDENTIFYING INFORMATION		TAG			DATE
		d Medicine Aide (QMA) 2			correction is prepared and		
	covered.	24's catheter bag should be			executed pursuant to Sacred		
	covered.				Heart's obligations under fede	rai	
	Resident 24's record was reviewed on 1/2/24 at				and state law.		
		oses included multiple sclerosis,			F TAG 583 - S/S= D		
	_	function of the bladder, and			F TAG 303 - 3/3		
		perplasia with lower urinary			Plan of Correction:		
	tract symptoms.				i idii oi ooncolon.		
					1.Corrective action for reside	ents	
	A review of Resident 24's current quarterly				noted to have been affected b		
	Minimum Data Set (MDS) dated 12/11/23				deficient practice.	,	
	indicated he had a Basic Interview for Mental				Resident #24 and #32 were		
	Status (BIMS) score of 14 (cognitively intact).				assessed by DON on 1/16/24	and	
	The MDS indicated Resident 24 used an				showed no ill effect. Care plai	าร	
	indwelling catheter				have been reviewed and updated		
					as needed. A dignity bag was		
		nt 24's current care plan titled		placed to provide privacy for the			
	indwelling cathet				resident on 1/16/24.		
		lder indicated the resident					
	_	idwelling catheter use, with a			1.How will the facility identify	/	
	_	4. Interventions included cover			other residents having the		
	catheter bag with a	dignity cover.			potential to be affected by the		
					same deficient practice?		
		ian orders dated 1/10/19					
		24's catheter and drainage bag			·All residents residing in the		
		as needed based on clinical			facility as of 1/16/24 have the		
	indicators.				potential to be affected.		
	In an interview on	1/3/24 at 2:45 PM, the Director					
		d the catheter bag should have			·All nurse computers were		
	been covered to ma	_			audited on 1/16/24 on each ur	nit	
	occir covered to ma	minum privacy.			and found to be in compliance		
	A current policy tit	led Procedure: Catheter Care.			community policy.	AAICII	
	A current policy titled Procedure: Catheter Care, Urinary, Last reviewed 12/17, provided by the			community policy.			
	•	g on 1/3/24 at 2:45 PM did not					
	indicated the resident's catheter should be				·No other residents residing	in	
	covered.				the facility as of 1/16/24 have		
					catheters.		
	2) During a medica	tion pass observation on 1/4/24					
			1		l .		1

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Event ID:

WA2K11 Facility ID: 000404

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155512	B. W	ING	01/08/2024		
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			MAIN ST		
ASCENIS	ION LIVING SACE	ED HEART VILLAGE			, IN 46710		
AUULINO	TOTA EIVING OACK	LD HEART VILLAGE		AVILLA	, 114 707 10		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+-	TAG	DEFICIENCY)		DATE
	_	ered Nurse (RN 3) was			1.The measures the facility v		
	observed preparing medications for Resident 32.				take or systems the facility will		
	After preparing the medications, RN 3 walked				alter to ensure that the proble		
		leaving it unattended with the			will be corrected and will not re	ecur.	
	computer screen open. Resident 32's protected						
	health information including her name and				The melian of		
	medications were visible on the screen to				•The policy and procedure		
		by. The cart was situated by			Confidentiality of Information a		
	within visual range	th residents and staff passing			Quality of life- Dignity has bee	T1	
	within visual range	of the cart.			reviewed by the IDT and is deemed appropriate.		
	During an observat	ion on 1/5/24 at 1:21 PM, RN 3			и чееттей арргорпате.		
	prepared a cup with pills in it and walked away				·Nursing staff will be re-educ	hated	
	from her cart with her computer screen open				by the DON or designee on	Jaieu	
		ormation visible. The cart was			Quality of Life- Dignity and		
	_	vay with staff and residnets			Confidentiality of Information b	nV	
	passing within visu			1/26/24			
	r6				1,20,2		
	During an interview	v on 1/4/24 at 8:55 AM, RN 3					
	_	d have closed her computer					
	screen prior to leav	ing the medication cart to			1.Quality Assurance Plans to	0	
	ensure privacy.				monitor facility compliance to		
					make sure that corrections are	•	
		d was reviewed on 1/8/24 at			achieved and permanent.		
		es included Vascular dementia,			·Under the direction of the		
		hotic disturbance, anxiety			Quality Assurance and Proces	ss	
	disorder, and hyper	tensive heart disease without			Improvement (QAPI) monthly		
	heart failure.				Committee meeting, the DON		
					designee will audit catheter ba	ng	
		nt 32's current quarterly MDS			coverings, and maintaining		
	i ·	icated Resident 32 had a BIMS			confidentiality during med pas		
	score of 12 (mild co	ognitive impairment).			times weekly to ensure cathet		
					dignity bags are in place at all		
		led Ascension Annual			times and that confidentiality is		
	_	2023, provided by the Director			maintained during med passes		
	of Nursing on 1/8/24 at 11:20 AM indicated staff				·Audits will be submitted and		
		ay from computers while			reviewed by the QAPI commit	tee	
		creen should have been locked			for management of ongoing	(*)	
		ber was away from the			compliance and will continue t	until	
l	computer.		1		90% compliance or greater is		I

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155512	B. W	ING		01/08/	2024
	PROVIDER OR SUPPLIER	ED HEART VILLAGE		515 N N	ADDRESS, CITY, STATE, ZIP COD MAIN ST , 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 APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3-1(p)(5)				achieved for a minimum of 4 continuous weeks. The administrator is respon for ensuring ongoing complian		
					1.Completion Date: 1/26/24		
					p="" dir="ltr" role="presentatio quality="" assurance="" plansito="" monitor="" facility="" compliance="" make="" sure=' that="" corrections="" are="" achieved="" and="" permanent.<="" p=""> p="" dir="ltr" role="presentatio under="" the="" direction="" of quality="" assurance="" and=" process="" improvement="" (q="" committee,="" don="" or="' designee="" will="" audit="" catheter="" bag="" coverings,= maintaining="" confidentiality= during="" med="" pass="" 2="' times="" weekly="" to="" ensure="" dignity="" bags="" are="" in="" place="" at="" all=that="" is="" maintained="" passes.<="" p=""> p="" dir="ltr" role="presentatio completion="" date:="" 1="" 26 24<="" p="">	="" n" '="" api) ' "" ""	
F 0610 SS=D Bldg. 00	§483.12(c) In resp	nt/Correct Alleged Violation conse to allegations of cploitation, or mistreatment,					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG <u>00</u>	COM	PLETED
		155512	B. WING		01/0	8/2024
	PROVIDER OR SUPPLIER	ED HEART VILLAGE	51	reet address, city, state 5 N MAIN ST /ILLA, IN 46710	E, ZIP COD	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DBOVIDEDIC DI AA	N OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREI			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA		ENCY)	DATE
	. , , ,	ve evidence that all alleged oughly investigated.				
	§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.					
	_ ·		F 0610	="" p=""> p="" dir="ltr" role= resident="" #4="" assessed="" by=' services="" on="" 24="" and="" sho ill="" effect.="" wi to="" follow="" up	'was="" "" social="" ' 1="" 19="" wed="" no=""	01/26/2024
	this writer's greeting	4 did not respond verbally to gs and continued to look at the		psych="" as="" ne	eeded. <=""	
	floor.			="" span=""> ="" p="">		
	10:16 AM. Diagnos anxiety disorder, m	was reviewed on 1/4/24 at ses included Down Syndrome, ajor depressive disorder, cified dementia, restlessness		Preparation and of plan of correction constitute Sacred admission to or a the facts alleged	n does not d Heart's ngreement with	
	(MDS) indicated th Status (BIMS) scor impairment). The M not displayed any b	et quarterly Minimum Data Set eir Basic Interview for Mental e was 1 (severe cognitive MDS indicated Resident 4 had ehaviors. The MDS indicated et to make themselves		set forth in the St Deficiencies, and specifically denie correction is prep executed pursual	tatement of I such liability is ad. The plan of pared and nt to Sacred	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155512	B. W	ING		01/08	/2024
				STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	£			MAIN ST		
ASCENS	ION LIVING SACR	ED HEART VILLAGE			, IN 46710		
	Г		-		.,		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG			DATE
	understood and was able to understand others.				and state law.		
	Dagidant 41a aver	t care plan entmy data d 2/0/22			F TAG 610 - S/S= D		
		t care plan entry dated 2/9/23		F 1AG 010 - 3/3- D			
	indicated the resident's family had reported a history of suicidal ideations. The target goal was				Plan of Correction:		
	for the resident to have no suicidal ideations				i ian oi conection.		
	through 11/30/23. Interventions included				1.Corrective action for reside	≥nts	
	_	ic services as needed, 1 to 1			noted to have been affected b		
		moods and monitor			deficient practice.	yuic	
	· · · · · · · · · · · · · · · · · · ·	ipsychotic medications.			·Residents #4 was assessed	d by	
		1 7			DON on 1/16/24 and showed	•	
	Resident 4's current care plan entry dated 5/1/23			effect. Care plans have been			
	indicated the resident had displayed behaviors of				reviewed and updated as needed.		
		sing medications, being					
		f during care and difficulty			·Resident #4 was assessed	by	
		te target goal was for Resident			Social Services on 1/19/24 and		
		usals through 11/30/23.			showed no ill effect. Resident #4		
	Interventions includ	led review of medications,		will continue to follow up with			
	allow choices, mon	itor and document behaviors,			psych services as needed.		
	ask for family input	and encourage					
	communication.				1.How will the facility identify	/	
					other residents having the		
		care plan entry dated 1/24/20			potential to be affected by the		
		nt had a life long history of		same deficient practice?			
		layed extreme tearfulness and					
		rget goals included attendance			Other residents residing in		
		eekly and no increase in			facility as of 1/16/24 who have		
		11/29/23. Interventions			unusual occurrences have the	!	
		visits, encourage socialization,			potential to be affected.		
		v the resident to select dining					
	medications.	onitor effectiveness of			·No other residents have be	on	
	medications.				identified to have had unusual		
	A progress note dat	ed 3/4/23 at 11:23 AM			occurrences as of 1/16/24.		
		4 had been found holding their			000011011003 03 01 1/10/24.		
		_					
	call light cord around their neck. Resident 4 did not respond to questions related to the call light						
	cord being around t				1.The measures the facility	will	
					take or systems the facility wil		
	A progress note dated 3/4/23 at 11:44 AM				alter to ensure that the proble		

DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/08/2024 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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE indicated Resident 4 did not display increased will be corrected and will not recur. depression symptoms, was pleasant and cooperative and had no thoughts of harming self ·The Administrator, DON and or thoughts of being better off dead. Resident 4's ADON will be re-educated by the call light cord was found lying on their bed regional nurse consultant or wrapped loosely numerous times with a loop lying designee on reporting unusual on the bed and wrapped around the bed rail. It occurrences on or before 1/26/24 was determined Resident 4 most likely got tangled or prior to working their next in the call light cord on accident. Resident 4's call scheduled shift. light was removed and replaced with a bell. ·The policy and procedure A progress note dated 3/6/23 at 9:33 AM noted as **Unusual Occurrence Reporting** a late entry for 3/4/23 indicated the incident was has been reviewed by the IDT and determined to not be a behavioral incident. is deemed appropriate. In an interview on 1/5/24 at 3:18 PM the Director of Nursing (DON) indicated Resident 4 having been found with their call light cord wrapped 1.Quality Assurance Plans to around their neck had not been investigated. The monitor facility compliance to DON indicated the event had not been reported to make sure that corrections are the Indiana Department of Health (IDOH). The achieved and permanent. DON indicated they did not believe the event was ·Under the direction of the an unusual occurrence. The Assistant Director of Quality Assurance and Process Nursing (ADON) indicated Resident 4 had an Improvement (QAPI) monthly exceptionally long call light cord. The ADON Committee meeting, the DON or indicated they did not believe Resident 4 had designee will evaluate all incidents formulated a plan to harm themselves. The ADON brought to daily clinical huddle indicated Resident 4 was pleasant, laughing and each week to determine if the denied the depression screen question of having incidents meet the criteria of thoughts of harming self or thoughts of being unusual occurrence that would better off dead. The DON indicated the facility did require reporting. not have a policy for suicidal ideation or suicide ·Audits will be submitted and precautions. reviewed by the QAPI committee for management of ongoing A current policy related to reportables dated 12/16 compliance and will continue until provided by the DON indicated the facility was to 90% compliance or greater is

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3.1-28(d)

report adverse events or unusual occurrences as

required by federal or state regulations.

Event ID:

WA2K11

Facility ID: 000404

achieved for a minimum of 4

The administrator is responsible

for ensuring ongoing compliance.

continuous weeks.

If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155512	A. BU B. WI	ILDING NG	00	COMPLE 01/08/2	
		100012	D. WI			01/08/2	<u> </u>
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD MAIN ST		
ASCENS	ION LIVING SACRI	ED HEART VILLAGE	AVILLA, IN 46710				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
	3.1-28(e)				1.Completion Date: 1/26/24 ="" p=""> p="" dir="Itr" role="presentatio corrective="" action="" for="" residents="" noted="" to="" have="" been=" affected="" b the="" deficient="" practice.<= p=""> p="" dir="Itr" role="presentatio residents="" #4="" was="" assessed="" by="" don="" on= 1="" 16="" 24="" and="" showed="" no="" ill="" effect. = care="" plans="" have="" beer reviewed="" updated="" as="" needed. <="" p=""> p="" dir="Itr" role="presentatio resident="" #4="" was="" assessed="" by="" social="" services="" on="" 1="" 19="" 24="" and="" showed="" no="" ill="" effect.="" will="" continue to="" follow="" up="" with="" psych="" as="" needed. <="" p=""> p="" dir="Itr" role="presentatio how="" dir="Itr" role="presentatio how="" as="" needed. <="" p=""> p="" dir="Itr" role="presentatio how="" as="" needed. <="" p=""> p="" dir="Itr" role="presentatio how="" as="" needed. <="" p="""> p="" dir="Itr" role="presentatio how="" residents= having="" potential="" to="" be affected="" by="" same="" deficient="" practice?<="" p=""	y="" "" "" "" "" "" "" "" "" "" "" "" ""	
					p="" dir="ltr" role="presentatio other="" residents="" residing= in="" the="" facility="" as="" of:	=""	

PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155512	A. BUILDING B. WING	00	COMPLETED 01/08/2024
	ROVIDER OR SUPPLIER	ED HEART VILLAGE	515 N I	ADDRESS, CITY, STATE, ZIP COD MAIN ST A, 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)	(X5) COMPLETION DATE
				1="" 16="" 24="" who="" have had="" unusual="" occurrence potential="" to="" be="" affected. =""	
				p="" dir="ltr" role="presentation the="" measures="" facility="" will="" take="" or="" systems= alter="" to="" ensure="" that = problem="" be="" corrected=" and="" not="" recur.<="" p="";	
				p="" dir="ltr" role="presentation the="" administrator,="" don=" and="" adon="" will="" be="" re-educated="" by="" regional nurse="" consultant="" or="" designee="" on ="" reporting= unusual="" occurrences="" or before="" 1="" 26="" 24="" prior="" to="" working="" their next="" scheduled="" shift.<=" p="">	="" ="" =""
				p="" dir="ltr" role="presentation the="" policy="" and="" procedure="" unusual="" occurrence="" reporting="" had been="" reviewed="" by="" idt is="" deemed="" appropriate." p="">	ns="" =""
				p="" dir="ltr" role="presentation quality="" assurance="" plans to="" monitor="" facility="" compliance="" make="" sure= that="" corrections="" are=""	=""

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WA2K11 Facility ID: 000404

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	OF CORRECTION	IDENTIFICATION NUMBER 155512	A. BUILDING B. WING	00	COMPLETED 01/08/2024			
	ROVIDER 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				achieved="" and="" permanent.<="" p=""> p="" dir="Itr" role="presentation under="" the="" direction="" or quality="" assurance="" and=" process="" improvement="" (c ="" monthly="" committee="" meeting,="" don="" or="" designee="" will="" evaluate=" all="" incidents="" brought="" to="" daily="" clinical="" huddleach="" week="" determine=" if="" meet="" criteria="" unusual="" occurrence="" that would="" require="" reporting.p=""> p="" dir="Itr" role="presentation audits="" will="" be="" submitted="" and="" reviewed by="" the="" qapi="" committee="" for="" management="" of="" ongoing compliance="" continue="" until="" 90%="" or="" greater= is="" achieved="" a="" minimum="" 4="" continuous= weeks.<="" p=""> p="" dir="Itr" role="presentation the="" administrator="" is="" responsible="" for="" ensuring ongoing="" compliance. p="" dir="Itr" role="presentation completion="" date:="" 1="" 26 24<="" p=""> ="" span=""> ="" span=""> ="" span=""> ="" dir="Itr" role="presentation completion="" date:="" 1="" 26 24<="" p=""> ="" span=""> ="" span=""> ="" dir="Itr" role="presentation completion="" date:="" 1="" 26 24<="" p=""> ="" span=""> ="" dir="Itr" role="presentation corrective="" action="" for=""	f="" "" e="" <="" on" =="" on" f="" on" f="" on" f=""			

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155512		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/08/2024			ETED	
	155512	B. WI	NG		01/08/	2024
PROVIDER OR SUPPLIE	R RED HEART VILLAGE		515 N N	ADDRESS, CITY, STATE, ZIP COD MAIN ST ., IN 46710		
ION LIVING SACE SUMMARY (EACH DEFICIEN			515 N N	MAIN ST	y="" "" -"" ="" =""	(X5) COMPLETION DATE
				p="" dir="itr" role="presentation other="" residents="" residing= in="" the="" facility="" as="" of= 1="" 16="" 24="" who="" have= had="" unusual="" occurrence potential="" to="" be="" affected. ="" <="" span	:"" ="" =""	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $WA2K11 \quad \ \ \text{Facility ID:} \quad \ 000404$

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/24/2024 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155512	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/08/2024
	PROVIDER OR SUPPLIES	ED HEART VILLAGE	515 N	ADDRESS, CITY, STATE, ZIP COD MAIN ST 4, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	
				p="" dir="Itr" role="presenta the="" measures="" facility= will="" take="" or="" system alter="" to="" ensure="" that problem="" be="" corrected and="" not="" recur.<="" sp p="" dir="Itr" role="presenta the="" administrator,="" dor and="" adon="" will="" be=" re-educated="" by="" region nurse="" consultant="" or=" designee="" on ="" reporting unusual="" occurrences="" before="" 1="" 26="" 24="" prior="" to="" working="" the next="" scheduled="" shift. span=""> p="" dir="Itr" role="presenta the="" policy="" and="" procedure="" unusual="" occurrence="" reporting="" been="" reviewed="" by="" is="" deemed="" appropriati span="">	="" is="" t ="" t ="" an=""> ation" n="" "" mal="" g="" on="" eir="" ation" has="" idt=""
				p="" dir="ltr" role="presenta quality="" assurance="" pla to="" monitor="" facility="" compliance="" make="" sur that="" corrections="" are=" achieved="" and="" permanent.<="" span=""> p="" dir="ltr" role="presenta	ns="" re="" ""

under="" the="" direction="" of=""

PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER 155512	(X2) MULTIPLE CO A. BUILDING B. WING	00		SURVEY LETED 1/2024	
	ROVIDER OR SUPPLIER ON LIVING SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP COD 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE	
			quality="" assurance="" a process="" improvement= ="" monthly="" committee meeting,="" don="" or="" designee="" will="" evalua all="" incidents="" brough to="" daily="" clinical="" h each="" week="" determined if="" meet="" criteria="" unusual="" occurrence="" would="" require="" reportspan=""> p="" dir="ltr" role="presert audits="" will="" be="" submitted="" and="" revie by="" the="" qapi="" committee="" for="" management="" of="" ong compliance="" continue=" until="" 90%="" or="" greatis="" achieved="" a="" minimum="" 4="" continue weeks.<="" span=""> p="" dir="ltr" role="preserthe="" administrator="" is responsible="" for="" ens ongoing="" compliance.< p="" dir="ltr" role="preser how="" dir="ltr" role="preser how="" dir="ltr" role="preser how="" span=""> p="" dir="ltr" role="preser how="" for="" facilidentify="" other="" facilidentify="" other="" reside having="" potential="" to= affected="" by="" same=" deficient="" practice?<="" p="" dir="ltr" role="preser deficient="" p="" dir="lt	e"" (qapi) ="" ate="" tt="" uddle="" ting. <="" ttation" ewed="" ttation" ="" euring="" ="" span ttation" euring="" euring=" euring=""		

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Event ID:

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155512		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/08/2024	
	ROVIDER OR SUPPLIE	R RED HEART VILLAGE	515 N	ADDRESS, CITY, STATE, ZIP COD MAIN ST A, IN 46710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETION DATE	
				other="" residents="" residings in="" the="" facility="" as="" of 1="" 16="" 24="" who="" have had="" unusual="" occurrence potential="" to="" be="" affected. =""	="" =""	
				p="" dir="ltr" role="presentation the="" measures="" facility="" will="" take="" or="" systems= alter="" to="" ensure="" that = problem="" be="" corrected="" and="" not="" recur.<="" p="">	1111 1111 1	
				p="" dir="ltr" role="presentation the="" administrator,="" don=" and="" adon="" will="" be="" re-educated="" by="" regional nurse="" consultant="" or="" designee="" on ="" reporting= unusual="" occurrences="" on before="" 1="" 26="" 24="" prior="" to="" working="" their next="" scheduled="" shift.<=' p="">	" ="" ="" =""	
				p="" dir="ltr" role="presentation the="" policy="" and="" procedure="" unusual="" occurrence="" reporting="" ha been="" reviewed="" by="" idt is="" deemed="" appropriate p="">	s="" =""	
				p="" dir="ltr" role="presentation quality="" assurance="" plans to="" monitor="" facility=""		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPL	
		155512	B. WINC	j		01/08/	/2024
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
			I		MAIN ST		
ASCENS	OION LIVING SACE	RED HEART VILLAGE	<u></u>	AVILLA,	, IN 46710		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	-	TAG	compliance="" make="" sure=		DATE
					that="" corrections="" are=""		
					achieved="" and=""		
					permanent.<="" p="">		
					p="" dir="ltr" role="presentatio	n"	
					under="" the="" direction="" of		
					quality="" assurance="" and="		
					process="" improvement="" (c	,	
					="" committee,="" don="" or="		
					designee="" will="" evaluate=' all="" incidents="" brought=""		
					to="" daily="" clinical="" huddle	e=""	
					each="" week="" determine="		
					if="" meet="" criteria=""		
					unusual="" occurrence="" that	=""	
					would="" require="" reporting.	<=""	
					p="">		
					p="" dir="ltr" role="presentatio		
					completion="" date:="" 1="" 26 24<="" p="">)=	
					21 · P ·		
F 0684	483.25						
SS=D	Quality of Care						
Bldg. 00	§ 483.25 Quality						
	· ·	a fundamental principle that					
		tment and care provided to					
	facility residents.	ssessment of a resident, the					
	-	re that residents receive					
		re in accordance with					
	professional stan	dards of practice, the					
		erson-centered care plan,	1				
	and the residents						
		on, interview and record	F 0684	4	="" p="">		01/26/2024
		failed to ensure MD orders were					
		cal spine fracture management in			Preparation and execution of	inis	
	(Resident 181).	viewed for quality of care.	1		plan of correction does not constitute Sacred Heart's		
	(Kesidelli 101).				admission to or agreement with	th	
	Findings include:				the facts alleged or conclusion		
1	l S		1			Į.	l

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	TED
		155512	B. W	ING		01/08/2	2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			MAIN ST		
ASCENS	ION LIVING SACE	ED HEART VILLAGE			, IN 46710		
ASCENS	ION LIVING SACK	ED HEART VILLAGE		AVILLA	i, IN 407 IO		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					set forth in the Statement of		
	_	ion on 1/2/24 at 1:05 PM,			Deficiencies, and such liability	is	
		itting in his recliner watching			specifically denied. The plan o	f	
		ident's cervical collar (C-collar)			correction is prepared and		
	was in a chair acros	ss the room.			executed pursuant to Sacred		
					Heart's obligations under fede	ral	
		1/2/24 at 1:08 PM, Resident 181			and state law.		
		pposed to wear the C-collar,					
	but the staff never puts the C-collar back on.				F TAG 684- S/S= D		
	Resident 181's reco	rd was reviewed on 1/7/24 at			Plan of Correction:		
	2:47 PM. Diagnoses included a fall from a						
	motorized mobility scooter resulting in C2				1.Corrective action for reside	ents	
	odontoid process fracture, bilateral hearing loss,				noted to have been affected b	y the	
	and mild cognitive	impairment of unknown origin.			deficient practice.		
	B 11 . 1011				·Residents #181 was assess	sed	
		ent admission Minimum Data		by the DON on 1/16/24 and			
		2/26/23, indicated his Basic			showed no ill effect. Care plan		
		al Status (BIMS) score was 10			have been reviewed and upda	ited	
		e impairment). The MDS			as needed.		
		month prior to admission he					
		ated fracture. The MDS			1.How will the facility identify	/	
	indicated the reside	-			other residents having the		
		nce for transfers and			potential to be affected by the		
		d a walker or manual			same deficient practice?		
		DS indicated he was receiving					
	occupational and pl	nysicai inerapy.			·All residents residing in the		
	D: 1 4 1011				facility as of 1/16/24 that requi	re a	
		ent Care plan, dated 6/26/23,			brace to be applied have the		
	1	nce with Care and Orders			potential to be affected.		
		nt refused to wear his C-collar					
		l he would not have an injury			Desidents were such at all	_	
		ear the C-collar. Interventions			Residents were evaluated t		
	wear his C-collar.	ing the resident's refusal to			ensure the resident was weari	-	
	wear ms C-conar.				brace as ordered. If a resident		
	A physician and and	dated 12/26/23 indicated			found to not have a brace on a		
		dated 12/26/23 indicated ollar was to be worn at all times.			ordered brace will be applied and		
	Resident 181's C-co	onal was to be worn at all times.			the resident will be assessed f		
	Th and 1115 - 11	otion in the manning			any adverse effects. Care plar		
	i nere was no indica	ation in the nursing progress			will be reviewed and updated	as	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155512	B. W	NG		01/08/	/2024
	PROVIDER OR SUPPLIED	R ED HEART VILLAGE		515 N I	ADDRESS, CITY, STATE, ZIP COD MAIN ST A, IN 46710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA	.IE	DATE
	notes dated 1-1-24	through 1-3-24 the resident			needed.		
	refused to wear his	C-collar except for a note					
	dated 1/3/24 at 6:30 PM when a nursing note was entered regarding the resident's refusal. In an interview on 1/2/24 at 1:15 PM, LPN 6						
					1.The measures the facility	will	
		181 was to wear his C-collar			take or systems the facility wil		
	_	alking around. After a request			alter to ensure that the proble		
		, LPN 6 indicated she was			will be corrected and will not r	ecur.	
	· ·	esident was to have the			All disease of the state of the		
C-collar on at all times. LPN 6 went to Resident				·All direct care licensed nurs			
181's room and immediately placed the C-collar on the resident.				and CNAs will be re-educated DON or designee on ensuring	-		
the resident.				braces are applied and remov			
	In an interview on	1/8/23 at 9:26 AM, the DON			per physician order on or befo		
		181 was to wear his C-collar at			1/19/24 or prior to working the		
	all times.	TOT Was to Wear Into C Contac at			next scheduled shift.		
		1/8/23 at 9:26 AM, the DON			·The policy and procedure		
		y had no policy for ensuring			Health Care Provider Orders I		
		ere in place. No policy was			been reviewed by the IDT and	i IS	
	provided by survey	exit.			deemed appropriate.		
	3.1-37						
					1.Quality Assurance Plans t	0	
					monitor facility compliance to		
					make sure that corrections are	e	
					achieved and permanent.		
					Under the direction of the		1
					Quality Assurance and Proces	SS	
					Improvement (QAPI) monthly		
					Committee meeting, the DON		
					designee will audit 3 resident's		
					with an order for a brace to be		
					applied 3x a week to ensure the		
					brace is applied and removed	as	1
					ordered. ·Audits will be submitted and	۸	
					reviewed by the QAPI commit		
I	1		- 1		I reviewed by the QAPI commit	ICC	1

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155512	B. W	ING		01/08	/2024
		l .	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			MAIN ST		
ASCENS	ION LIVING SACR	ED HEART VILLAGE			, IN 46710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					for management of ongoing		
					compliance and will continue t	untii	
					90% compliance or greater is achieved for a minimum of 4		
					continuous weeks.		
					·The administrator is respon	ciblo	
				for ensuring ongoing complian			
					lor ensuring origoning compilar	ice.	
				1.Completion Date: 1/26/24			
					1.completion Bate. 1/20/21		
F 0689	483.25(d)(1)(2)						
SS=D	Free of Accident						
Bldg. 00	Hazards/Supervis						
	§483.25(d) Accide						
	The facility must e						
		e resident environment					
		faccident hazards as is					
	possible; and						
	§483.25(d)(2)Eacl	h resident receives					
	adequate supervis	sion and assistance devices					
	to prevent accider						
		and record review the facility	F 0	589			01/26/2024
		precaution interventions were			="" p="">		
		irect care staff members for 1 of					
		d (Resident 15). This resulted					
		fall that required emergency			Preparation and execution of t	his	
	department interver	ntion for Resident 15.			plan of correction does not		
	Findings include:				constitute Sacred Heart's	·h	
	rmanigs include:				admission to or agreement wit the facts alleged or conclusion		
	On 1/2/2/Lat //// D	M the facility reported Resident			set forth in the Statement of	io	
		a fall on 1/1/24 at 4:30 PM. The			Deficiencies, and such liability	ie	
	_	laceration that required			specifically denied. The plan of		
	sutures.	ractation that required			correction is prepared and	' 1	
					executed pursuant to Sacred		
	Resident 15's record	d was reviewed on 1/5/24 at			Heart's obligations under fede	ral	
	-	es included Alzheimer's, major			and state law.		
		dementia, restless leg			="" n="">		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLI	
		155512	B. W	ING		01/08/	2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	L			MAIN ST		
ASCENS	ION LIVING SACR	ED HEART VILLAGE			A, 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	ATE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	syndrome and conti	actures to the left hand.					
					F TAG 689 - S/S= D		
		nt 15's most recent annual			="" p="">		
		(MDS) dated 8/23/23 indicated			n		
		w for Mental Status (BIMS)			Plan of Correction:		
		cognitive loss). Resident 15			="" p="">		
		assistance to roll left and right			1 Compostive author for		
		dent was dependent on staff to			1.Corrective action for resid		
	change position from lying in bed to sitting on the side of the bed. The resident was dependent on				noted to have been affected b	y ine	
	staff to change position from sitting on the side of				deficient practice. Resident #15 was assesse	d by	
	the bed to lying in the bed and was dependant for				DON on 1/16/24 and showed	,	
	2 assist with sitting balance. Resident 15 was				further ill effect. Care plans h		
	dependent on staff for transfers from a bed to a				been reviewed and updated a		
	chair and from a ch				needed.	15	
	chan and from a ch	an to a sed.			="" p="">		
	Δ nhysician orders	dated 9/20/21 indicated			- β- /		
		have a Broda (an assistive			1.How will the facility identif	., I	
		all prevention) chair for proper			other residents having the	,	
	positioning.	an provenion, enan rer preper			potential to be affected by the		
	1				same deficient practice?		
	Resident 15's curre	nt care plan entry dated			="" p="">		
		/13/23 indicated the resident					
		or fall related injuries. The			·Other residents residing in	the	
		iced risk for falls and fall			facility as of 1/16/24 who are		
		ugh 2/2/24. An intervention			dependent on staff for position	ning	
		ated Resident 15 was to be			and transfers have the potent	-	
	seated in a reclined	position in their Broda chair at			be affected.		
		ing meals. An intervention					
	dated 5/5/20 indicat	ed staff were to assist with all					
	transfers. An interv	ention dated 1/1/24 indicated			·These residents were asse	ssed	
	Resident 15 was no	t to be seated on the side of			for appropriate fall intervention	ns by	
	the bed until ready	for transfer. Interventions did			ADON on 1/17/24. Care plan	s	
		stance of 2 staff members for			were reviewed and updated a	s	
		ne interventions did not			needed.		
	include a mechanical lift for resident transfer.				="" p="">		
	Recident 15's undet	ed care card (milde to CNA			·A care card audit was		
		ed care card (guide to CNA staff members indicated the					
	1	for falls. Resident 15 required			completed for residents with fa		
	resident was at HSK	ioi iano. Neoruent 19 requireu	1		interventions by the ADON on	I	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155512	B. W	ING		01/08	/2024
		<u> </u>	1	CTDEET .	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			MAIN ST		
VSCENIS		ED HEART VILLAGE			MAIN 51 A, IN 46710		
ASCENS	ION LIVING SACK	ED HEART VILLAGE		AVILLA	A, IIN 407 IU		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(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	<u> </u>	TAG	DEFICIENCY)		DATE
		taff member for bed mobility,			1/17/24 and was updated as		
	required a Broda ch	nair, required a mechanical lift			needed.		
		as not to be placed in a sitting			="" p="">		
	position on the side	of the bed until ready for					
		resident having poor trunk					
	strength (dated 1/1/	(24).			1.The measures the facility		
					take or systems the facility wil	l	
		ted 1/1/24 at 8:04 PM indicated			alter to ensure that the proble		
	Resident 15 had a witnessed fall at 4:30 PM. The				will be corrected and will not re	ecur.	
	note indicated staff had been preparing Resident				="" p="">		
	15 to take a shower and had placed the resident						
	up on the bed. The note indicated Resident 15 slid				·All CNA's will be re-educate	ed	
	to the left, hit the bedside table splitting her lip.				by DON or designee on fall		
					prevention on or before 1/26/2		
		y Team (IDT) progress note			="" p="">		
		PM indicated a Certified Nurse					
		Resident 15 on the side of the			·The policy and procedure F	all	
		y to remove items from the			Prevention has been reviewed	d by	
		licated Resident 15 had poor			the IDT and is deemed		
	trunk control.				appropriate.		
					="" p="">		
		Review dated 11/22/23					
		15 had a fall risk score of 22					
	, ,	e review indicated Resident 15					
		d and required extensive staff					
		ities of daily living (bathing,			1.Quality Assurance Plans to	0	
		or out of bed or chair, eating			monitor facility compliance to		
		dent 15 required the assistance			make sure that corrections are	9	
	of 2 staff members	tor transfers.			achieved and permanent.		
	A T 1 G 5	CIL 1d C			·Under the direction of the		
		epartment of Health Survey			Quality Assurance and Proces	SS	
	_	indicated Resident 15 had			Improvement (QAPI) monthly		
		on 1/1/24 at 4:30 PM. The report			Committee meeting, the ADOI		
	_	aced Resident 15 on the side of			designee will audit transfers fo		
	the bed and turned away to remove items from the				residents who are dependent		
	closet. Resident 15 slid to the side and hit their lip				staff for transfers each week to	0	
		e. The report indicated			ensure fall interventions are		
		BIMS score of 0, used a Broda			implemented at the time of		
		g and required staff assistance			transfer.		
	for transfers.		1		·Audits will be submitted and	d	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155512	B. W	ING		01/08/	2024
		<u> </u>	1	STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t .			MAIN ST		
ASCENS	ION LIVING SACR	ED HEART VILLAGE			, IN 46710		
			1		, T	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	+	TAG		4	DATE
	In an inter	1/5/24 at 12:10 PM the Director			reviewed by the QAPI commit	tee	
					for management of ongoing		
		indicated according to MDS			compliance and will continue u	until	
		ent 15 was not physically			90% compliance or greater is		
		n the side of the bed alone and			achieved for a minimum of 4		
	did not fall during a transfer. The DON indicated Resident 15 was being prepared for transfer to the				continuous weeks.		
	shower chair when the fall occurred.				·The administrator is respon		
	snower chair when	the fall occurred.			for ensuring ongoing complian	ice.	
	In an intanvi 1	1/5/24 at 1:02 DM Ovalid-1					
		1/5/24 at 1:03 PM Qualified			1 Completion Detail 1/20/04		
	Medication Aide (QMA) 4 indicated on 1/1/24 Resident 15 had a witnessed fall from the bed to				1.Completion Date: 1/26/24 ="" p="">		
					= p= >		
	the floor. A CNA had positioned the resident in a sitting position on the side of the bed and the						
					!!! -!:- !!!!!!- !!4-4:-	"	
		way. The CNA who left the			p="" dir="ltr" role="presentatio	n	
	_	he side of the bed unattended			corrective="" action="" for=""		
	_	agency. Resident 15 slid from			residents="" noted="" to=""	""	
	_	bedside table before falling to d have not been left sitting on			have="" been="" affected="" b	-	
		unattended. QMA 4 indicated			the="" deficient="" practice.<= p="">		
		ard had been updated to			p= " dir="ltr" role="presentatio	n"	
		the resident sitting on the side			resident="" #15="" was=""	11	
	_	ed on 1/1/24 after the resident			assessed="" by="" don="" on=	,,,,,,	
		ted Resident 15 was ready for			assessed= by= don= on= 1="" 16="" 24="" and=""	•	
		r CNA had left the room to			1- 16- 24- and- showed="" no="" further="" ill=	.""	
	retrieve a shower ch				effect. ="" care="" plans=""		
					have="" been="" reviewed=""		
	A current noticy day	ted 12/17 provided by the			updated="" as="" needed. <="	"	
		documentation of identified			p="">		
		d be maintained in the clinical			-		
		e to the direct care associates.			p="" dir="ltr" role="presentatio	n"	
	150014 and available	and the difference and appropriates.			how="" will="" the="" facility=""		
	3.1-45(a)				identify="" other="" residents=		
	·• ()				having="" potential="" to="" be		
					affected="" by="" same=""	,	
					deficient="" practice?<="" p=""	'>	
					denoicit practice: \= p=	-	
					p="" dir="ltr" role="presentatio	n"	
					other="" residents="" residing=		
					in="" the="" facility="" as="" of		
			1		- - - ao ty- as- 0	_	

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T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155512	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/08/2024
ROVIDER OR SUPPLIER	ED HEART VILLAGE	515 N I	ADDRESS, CITY, STATE, ZIP COD MAIN ST A, IN 46710	
ION LIVING SACRI SUMMARY S (EACH DEFICIEN		515 N I	MAIN ST	DATE "" "" "" "" "" "" "" "" "" "" "" "" "

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Event ID:

WA2K11 Facility ID: 000404

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155512		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/08/2024	
	PROVIDER OR SUPPLIER	ED HEART VILLAGE	515 N	ADDRESS, CITY, STATE, ZIP COD MAIN ST A, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
				p="" dir="ltr" role="present quality="" assurance="" plato="" monitor="" facility="" compliance="" make="" suthat="" corrections="" are= achieved="" and="" permanent.<="" p=""> p="" dir="ltr" role="present under="" the="" direction=" quality="" assurance="" ar process="" improvement=" ar process="" improvement=" achieved="" will="" audit=" transfers="" for="" 3="" residents="" who="" are="" dependent="" on="" staff=" each="" week="" to="" ens fall="" interventions="" implemented="" at="" time transfer. <="" p=""> p="" dir="ltr" role="present completion="" date:="" 1=" 24<=""" p="">	ans="" ire="" ation" "" of="" nd="" "" (qapi) or="" "" sure="" =""
F 0693 SS=D Bldg. 00	§483.25(g)(4)-(5) (Includes naso-ga tubes, both percut gastrostomy and piejunostomy, and resident's comprefacility must ensur §483.25(g)(4) A reto eat enough alor	stric and gastrostomy aneous endoscopic percutaneous endoscopic enteral fluids). Based on a hensive assessment, the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155512		A. BUILDING <u>00</u> COM			(X3) DATE COMPL 01/08 /	ETED	
	PROVIDER OR SUPPLIER	ED HEART VILLAGE		515 N N	ADDRESS, CITY, STATE, ZIP COD MAIN ST ., 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
	feeding was clinical consented to by the \$483.25(g)(5) A remeans receives the and services to releating skills and to enteral feeding in aspiration pneumodehydration, metanasal-pharyngeal Based on observation of the facility of formula was labeled reviewed (Resident Findings include: During an observation of the bag and tubing the formula type or the formula type or the formula type or the bag was observed with the liquid in the tubing pole holding the tubility is recorded.	esident who is fed by enteral the appropriate treatment store, if possible, oral to prevent complications of cluding but not limited to onia, diarrhea, vomiting, bolic abnormalities, and ulcers. In interview, and record sailed to ensure tube feeding and dated for 1 of 1 resident and dated for 1 of 1 resident and the recliner in assucent bag of about an inching engaged in a tube feeding to Resident 71's gastric tube. Were not dated or labeled with orders for administration. In on on 1/4/24 at 3:02 PM, served sitting in the recliner in the aguest. A tube feeding with about 1/2 inch of tan draped over the top of the feeding pump. No date or the bag. It was reviewed on 1/4/24 at sincluded amyotrophic lateral we bulbar palsy, and	F 0	693	="" p=""> Preparation and execution of the 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 specifically denied. The plan of correction is prepared and executed pursuant to Sacred Heart's obligations under federand state law. F TAG 693 - S/S= D Plan of Correction: 1.Corrective action for resident noted to have been affected by deficient practice. Resident #71 was assessed the DON on 1/17/24 and shown ill effect. Care plans have reviewed and updated as need 1. How will the facility identify	h is is is of is and is is of is and is is of it is is of it is in the interior of its interio	01/26/2024

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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 00 COMPLETED				
		155512	B. WING 01/08/2024			2024	
NAME OF T	DOMDED OF CHIPPLYEE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	S.			MAIN ST		
ASCENS	ION LIVING SACR	ED HEART VILLAGE	AVILLA, IN 46710				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	Ţ	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nt 71's significant change			other residents having the		
		(MDS) dated 9/26/23 indicated			potential to be affected by the		
		for Mental Status (BIMS)			same deficient practice?		
		itively intact). The MDS			Other residents residing in	41a a	
	indicated the reside	nt received a tube feeding.			Other residents residing in facility as of 1/16/24 who have		
	A raviany of physici	an orders dated 11/28/23			facility as of 1/16/24 who have		
		should be administered at 60			G-tubes have the potential to affected.	ne	
		garoo pump starting at 10:00			anected.		
	PM and stopping at						
	1 w and stopping at	10.00 / 11/1.			·There are no other resident	_s	
	In an interview on 1	1/5/24 at 9:32 AM, the Director			residing in the facility that have	I	
	of Nursing (DON) indicated tube feeding bags				g-tube feedings as of 1/16/24.		
		e changed daily, labeled, and					
	-	d she was unable to confirm					
		since the bag and tubing					
	were not labeled an						
					1.The measures the facility	will	
	A current policy titl	ed Procedure: Enteral Tube			take or systems the facility wil		
	Feeding Via Contin	uous Pump dated 1/24			alter to ensure that the proble	em	
	provided by the DC	N on 1/5/24 at 11:28 AM			will be corrected and will not re	ecur.	
	indicated the bag sh	ould be labeled with initials,					
		ormula was hung and initials			·Nurses will be re-educated	by	
	that the label was cl	hecked against the order.			the DON or designee on tube		
					feeding procedure for enteral		
	3.1-44(a)(2)				feeding via continuous pump of		
					before 1/26/24 or prior to work	king	
					their next scheduled shift.		
					·The policy and procedure		
					Enteral tube feeding via		
					continuous pump has been		
					reviewed by the IDT and is		
					deemed appropriate.		
					1.Quality Assurance Plans to	。	
					monitor facility compliance to		
					make sure that corrections are	e	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155512		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/08/2024		
	ROVIDER OR SUPPLIE ON LIVING SACF	RED HEART VILLAGE	515 N I	ADDRESS, CITY, STATE, ZIP COI MAIN ST A, IN 46710	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	achieved and permanen	the Process onthly DON or sidents sure date tube tekly to sare ed and ommittee oing tinue until ter is of 4 esponsible mpliance. 26/24 ntation" d="" by="" ce.<="" ntation"	DATE
				assessed="" by="" the=" on="" 1="" 17="" 24="" a showed="" no="" ill="" ef care="" plans="" have="" reviewed="" updated=""	" don="" nd="" fect. ="" " been=""	

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Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155512		A. BUII B. WIN	LDING	00	COMPL 01/08/	ETED	
	ROVIDER 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 LISC IDENTIFYING INFORMATION	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					needed. <=""" p=""> p="" dir="Itr" role="presentation how="" will="" the="" facility="" identify="" other="" residents=' having="" potential="" to="" be affected="" by="" same="" deficient="" practice?<="" p="" p="" dir="Itr" role="presentation other="" residents="" residing=in="" the="" facility="" as="" of=1="" 16="" 24="" who="" have=g-tubes="" potential="" to="" be="" affected.	"" =""" > '"" ="""	
					p="" dir="ltr" role="presentation the="" measures="" facility="" will="" take="" or="" systems=" alter="" to="" ensure="" that =" problem="" be="" corrected="" and="" not="" recur.<="" p=""> p="" dir="ltr" role="presentation nurses="" will="" be="" re-educated="" by="" the="" don="" or="" designee="" on=" tube="" feeding="" procedure= for="" enteral="" via="" continuous="" pump="" before 1="" 26="" 24="" prior="" to="" working="" their="" next="" scheduled="" shift.<="" p="">	" " "	
					p="" dir="ltr" role="presentation the="" policy="" and="" procedure="" enteral="" tube=' feeding="" via="" continuous="		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155512	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COMP	E SURVEY PLETED 3/2024
	ROVIDER OR SUPPLIEF	ED HEART VILLAGE	515 N	ADDRESS, CITY, STATE, ZIP C MAIN ST A, IN 46710	OD	
(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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE PPROPRIATE	(X5) COMPLETION DATE
				pump="" has="" been= reviewed="" by="" idt=' deemed="" appropriate	"" is=""	
				p="" dir="ltr" role="pres quality="" assurance=" to="" monitor="" facility compliance="" make=" that="" corrections="" a achieved="" and="" permanent.<="" p=""> p="" dir="ltr" role="pres under="" the="" directic quality="" assurance=" process="" improveme = "" committee,="" don= designee="" will="" auc residents="" with="" tut feedings="" to="" ensured date="" label="" are="" on="" feeding="" bags=times="" weekly="" label dated. <="" p=""> p="" dir="ltr" role="pres completion="" date:="" 24<="" p="">	" plans="" ="" " sure="" are="" eentation" on="" of="" " and="" nt="" (qapi) ="" or="" dit="" all="" oe="" present="" ="" 2="" eled=""	
F 0695 SS=E Bldg. 00	Suctioning § 483.25(i) Respir tracheostomy care The facility must e needs respiratory tracheostomy care	eostomy Care and ratory care, including e and tracheal suctioning. ensure that a resident who care, including e and tracheal suctioning, eare, consistent with				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155512	B. W	ING		01/08/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
ASCENS	SION LIVING SACE	ED HEART VILLAGE		515 N MAIN ST AVILLA, IN 46710			
AUULING	TOTALIVING OACK	LD HEART VILLAGE	-	AVILLA	, nv -tor 10		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		dards of practice, the					
		erson-centered care plan,					
	the residents' goals and preferences, and						
	483.65 of this sub	•		-			04/05/0004
		on, record review and	F 00	595	="" p="">		01/26/2024
		ty failed to ensure physician					
		ed and safe handling of			Preparation and execution of t	inis	
		ent was completed for 4 of 24			plan of correction does not		
		(Resident 9, Resident 24,			constitute Sacred Heart's	·la	
	Resident 36, and Re	esident 00).			admission to or agreement wit		
	Findings include:				the facts alleged or conclusion set forth in the Statement of	is	
	rindings include.				Deficiencies, and such liability	, io	
	1) During an obser	vation on 1/2/24 at 1:35 PM,			specifically denied. The plan of		
	, .	ng in her bed. Her nasal			correction is prepared and)	
	-	en tubing (a lightweight tube			executed pursuant to Sacred		
		s on one end and placed in the			Heart's obligations under fede	ral	
		ver supplemental oxygen) was			and state law.	iai	
		gen condenser (a medical			and state law.		
		ou extra oxygen) laying on the			F TAG 695 - S/S= E		
		inbagged. The oxygen			1 1710 000 070 2		
		ter was turned to 2 liters per			Plan of Correction:		
		ivering oxygen via the NC. Her					
		was positioned at the upper			1.Corrective action for reside	ents	
		d. The resident's portable			noted to have been affected b		
	oxygen condenser (a lightweight transportable			deficient practice.	-	
	oxygen condenser),	, not in use at that time, was			·Residents #9, 24, 36, 68 we	ere	
	sitting on the floor	with NC oxygen tubing			assessed by DON on 1/17/24	and	
	attached. The NC o	xygen tubing extended from			showed no ill effect. Care pla		
	the portable oxyger	unit and laid on the chair			have been reviewed and upda	ited	
		gen tubings attached to			as needed.		
		n condenser and portable			·Oxygen utilization was revi	ewed	
		were not labeled with the time			with the provider for resident #		
	and date the tubing	was changed.			and #68 and the order for oxy	-	
					use was discontinued, care pla	an	
	During an interview on 1/3/24 at 1:41 PM,				updated.		
	Resident 9 indicated she wore oxygen.						
					1.How will the facility identify	/	
		ion on 1/2/24 at 1:41 PM,			other residents having the		
	Licensed Practical	Nurse (LPN) 5 put the NC			potential to be affected by the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		155512	B. W	ING		01/08/	/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			MAIN ST			
ASCENS	SION LIVING SACR	ED HEART VILLAGE		AVILLA, IN 46710				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	oxygen tubing on Resident 9.				same deficient practice?			
	Decident O's record	was reviewed on 1/3/24 at 2:20			Other residents residing in	tho		
		luded chronic obstructive			Other residents residing in facility as of 1/16/24 who have			
	_	(COPD), obstructive sleep			order for oxygen therapy or	an		
	apnea (OSA), and i	· -			nebulizer treatments have the			
					potential to be affected.			
	Resident 9's curren	t significant change in status			potential to be allested.			
	Minimum Data Set (MDS) assessment, dated							
	10/31/23, indicated her Basic Interview of Mental				·These residents were asse	ssed		
	Status (BIMS) score was 8 (mild cognitive				by the DON on 1/17/24 and			
	impairment). The MDS indicated she had a lower				showed no ill effect. Care pla	ns		
	extremity impairment on one side and used a				were reviewed and updated a	s		
	manual wheelchair	. The MDS indicated the			needed.			
	resident required n	naximal assistance from staff to						
	_	l lying to sitting on the side of						
		pendent on staff to bed-to			·All oxygen and nebulizer			
		e MDS indicated the resident			treatment tubing was evaluate	d to		
		eath or trouble breathing when			ensure proper storage and da			
		e oxygen after arriving to the			of tubing change were indicate	ed on		
	facility.				1/17/24.			
		t care plan titled "Impaired Gas						
	-	ed the resident was dependent			1.The measures the facility	will		
		to COPD and OSA with a goal			take or systems the facility wil			
		diac symptoms of respiratory			alter to ensure that the proble			
		ons included to monitor			will be corrected and will not r	ecur.		
		nd change tubing and bubblers						
	per protocol or as o	ordered.			·Nursing staff will be re-edu	cated		
		1 . 110/10/22 : 11 . 1			by the DON or designee on			
		dated 10/19/23 indicated			respiratory care- prevention o			
		n was to be at 2 LPM via NC			infection, proper changing/dat	-		
	_	to keep oxygen sats above			of tubing and cleaning and sto	лаge		
	90%.				of nebulizer equipment on or	din a		
	A physician and and	dated 6/10/23 indicated			before 1/26/24 or prior to work	ung		
		dated 6/19/23 indicated			their next scheduled shift.			
	weekly on 3rd shift	n tubing was to be changed			The policy and presedure			
	weekly oil 51d Shift				•The policy and procedure	of		
	Resident 9's Medication Administration Record				Respiratory Care- prevention			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			COMPLETED	
		155512	B. W	ING		01/08/2024	
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			MAIN ST		
V & C E VI &		ED HEART VILLAGE			, IN 46710		
ASCENS	ION LIVING SACK	ED HEART VILLAGE		AVILLA	., IN 407 IU		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	indicated the oxyge	n tubing was changed at 5:00			IDT and is deemed appropriat	te.	
		/10/23, 12/17/23, 12/24/23 and					
	-	the oxygen tubing for the					
		and portable oxygen					
		changed on Sunday 12/31/23					
		labeled.2) During an			1.Quality Assurance Plans t	0	
		erview on 1/2/24 at 9:40 AM,			monitor facility compliance to		
		served lying in bed with a			make sure that corrections are	e	
	_	d in his nostrils, attached to an			achieved and permanent.		
		or beside the bed. The oxygen			·Under the direction of the		
		rned on and set to deliver 0			Quality Assurance and Proces	SS	
	liters of oxygen per minute. Qualified Medicine				Improvement (QAPI) monthly		
	Aide (QMA) 2 indicated the oxygen should have				Committee meeting, the DON		
	been set at 2 liters per minute and she did not				designee will audit 3 residents		
	•	en turned down to zero. QMA			with orders for oxygen therapy		
		unable to verify when the			nebulizer treatments 2 x's wee	•	
		been changed because she			to ensure physician orders are		
	was unable to find a	a date on the tubing.			followed and safe handling of	O2	
	D 11 . 04	1 1/4/04			and nebulizer equipment was		
		d was reviewed on 1/4/24 at			completed.		
	_	es included multiple sclerosis,			·Audits will be submitted and		
		eified, and personal history of			reviewed by the QAPI commit	tee	
	pulmonary embolis	m.			for management of ongoing	411	
	A marriant of D: 1	nt 24's augment avoitoils.			compliance and will continue	unui	
		nt 24's current quarterly (MDS) dated 12/11/23			90% compliance or greater is achieved for a minimum of 4		
		Basic Interview for Mental					
		e of 14 (cognitively intact).			continuous weeks. •The administrator is respon	sible	
	` ′	Resident 24 used oxygen.			for ensuring ongoing compliar		
	The MIDS maleated	resident 27 used Oxygen.				100.	
	A review of a care	plan titledhas pneumonia,					
		l inactive, included an			1.Completion Date: 1/26/24		
	approach indicating						
		ered. No current care plan					
		n use was available for review.					
	1						
	A review of physic	ian orders dated 11/6/23					
		nould be delivered at 2 liters					
	, , ,	cannula. A physician's order					
		ated oxygen tubing should be					
		, ,	ı			ı	

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Event ID:

WA2K11 Facility ID: 000404

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155512		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/08/2024	
	PROVIDER OR SUPPLIEF	ED HEART VILLAGE	515 N N	ADDRESS, CITY, STATE, ZIP COD MAIN ST A, 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION
	In an interview on loof Nursing (DON) is administered as ord changed weekly and 3) During an observat 10:52 AM, A restubing were observed dresser unbagged as seated in his wheeld using oxygen. He is oxygen in a while. Resident 36's record	vation and interview on 1/3/24 piratory treatment mask and ed lying on Resident 36's and undated. Resident 36 was chair in his room and was not indicated he had not used			
	obstructive pulmon of pulmonary embo dependence on supp				
	Minimum Data Set indicated his Basic	ent 36's current quarterly (MDS) dated 12/13/23 Interview for Mental Status 4 (cognitively intact).			
	labeled inactive, ind administer oxygen	nt 36's care plan, dated 1/22/21, cluded an approach to as ordered for shortness of care plans mentioning oxygen eview.			
	2/14/22 indicated of at a rate of 2 liters p shortness of breath. physician's order da should be administe minute via nasal car	physician's orders dated xygen should be administered ber minute via nasal cannula for An additional current ated 2/14/22 indicated oxygen bered at a rate of 2 liters per minula as needed for oxygen a 90 percent and shortness of			

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Event ID:

WA2K11 Facility ID: 000404

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155512		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/08/2024	
	PROVIDER OR SUPPLIER SION LIVING SACRED HEART VILLAGE	515 N N	ADDRESS, CITY, STATE, ZIP COD MAIN ST , IN 46710		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION breath.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLETION	
	In an interview on 1/3/24 at 2:45 PM, the DON indicated Resident 36's oxygen orders should be clarified, and respiratory equipment should be bagged when not in use. 4) During an observation on 1/2/24 at 10:26 AM Resident 68 was observed sitting in his wheelchair in his room. No oxygen was in use at the time of the observation. An oxygen concentrator was observed several feet from the foot of the bed with a nasal cannula lying on top of it, undated and unbagged. A nebulizer machine with tubing and a mask attached to it was lying undated and unbagged on a recliner chair in the room. During an observation on 1/8/24 at 9:39 AM, Resident 68 was observed lying on his bed with the oxygen concentrator positioned across the room and turned off.				
	Resident 68's record was reviewed on 1/3/24 at 9:44 AM. Diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and muscle weakness. A review of Resident 68's current quarterly MDS dated 10/9/23 indicated his BIMS score was 15 (cognitively intact). In an interview on 1/2/24 at 10:26 AM, Residnet 68 indicated he had not had oxygen on in "quite some time" A review of current physician's orders included the following orders dated 2/24/23: Change oxygen tubing and humidifier weekly on Sundays. Supplemental oxygen via nasal cannula at 3 liters				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155512		ì í	JILDING	instruction 00	(X3) DATE (COMPL 01/08/	ETED	
	PROVIDER OR SUPPLIER	ED HEART VILLAGE		515 N M	ADDRESS, CITY, STATE, ZIP COD MAIN ST , 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
	to keep sats greater may titrate.	than or equal to 90 percent,					
	Record for January indicating supplement 3 liters to keep sa	Medication Administration 2024, an order dated 2/24/23, ental oxygen via nasal cannula aturations greater than or equal titrate, was checked as given and 1/3/24.					
	at risk for respirat resident had a prob with a goal date of	nt 68's current care plan titled tory distress indicated the lem of shortness of breath, 1/9/24. Interventions included lministration device as ordered.					
		ss notes dated 1/4/24 at 2:44 lent 68 was using continuous er minute.					
	indicated respirator	1/3/24 at 2:45 PM, the DON y tubing should be bagged d oxygen orders should be					
	Medications Through dated 1/24 provided PM indicated respinched after use another resident's name	led Procedure: Administering gh a Small Volume Nebulizer d by the DON on 1/3/24 at 2:45 ratory equipment should be ad stored in a plastic bag with and date. The policy ment should be changed every					
	Administration date	led Procedure: Oxygen ed 12/22 provided by the DON M indicated oxygen tubing nd dated.					
	3.1-47(a)(6)						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155512		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/08/2024	
	PROVIDER OR SUPPLIER BION LIVING SACRED HEART VILLAGE	515 N I	ADDRESS, CITY, STATE, ZIP COD MAIN ST A, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review the facility failed to ensure insulin in a	F 0761	="" p="">	01/26/2024	
	medication cart was removed when expired for 1 of 29 residents and a medication refrigerator temperature was monitored for 1 of 2 medication rooms reviewed (Resident 16).		Preparation and execution of t plan of correction does not constitute Sacred Heart's admission to or agreement wit the facts alleged or conclusion	h	
	Findings include: 1. During an observation and interview on 1/5/24 at 1:21 PM, medication storage was reviewed with		set forth in the Statement of Deficiencies, and such liability specifically denied. The plan of correction is prepared and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>			ETED	
		155512	B. W	B. WING			01/08/2024	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
4005110		ED 115 A D.T. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			MAIN ST			
ASCENS	ASCENSION LIVING SACRED HEART VILLAGE			AVILLA	, IN 46710			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	Registered Nurse (RN) 3. A lispro insulin pen was				executed pursuant to Sacred			
	in the top drawer of the cart with an open date of				Heart's obligations under fede			
	12/1/23. The pen w	vas in a plastic bag with a			and state law.			
	printed label indica	printed label indicating it was for Resident 16. RN			F TAG 761- S/S= D			
	3 indicated the insulin was expired and should have been pulled from the cart and replaced with a							
	new pen.				Plan of Correction:			
		d was reviewed on 1/8/24 at			1.Corrective action for reside	ents		
	12:12 PM. Diagnoses included morbid obesity due to excess calories, pseudocyst of the pancreas, and chronic kidney disease, stage 3. A review of Resident 16's current significant				noted to have been affected b	y the		
					deficient practice.			
					·Residents #33 was assesse			
					by DON on 1/17/24 and show			
					no ill effect. Care plans have			
	-	Data Set (MDS) dated 11/28/23			reviewed and updated as need	ded.		
		Interview for Mental Status						
		6 (cognitively impaired). The			1.How will the facility identify	/		
		ılin was given during the			other residents having the			
	reference period.				potential to be affected by the			
		1 1 1 1 1 1 1 2 1 / 2 2			same deficient practice?			
		ian orders dated 11/21/23						
		spro was to be given			Other residents residing in			
	_	ording to a sliding scale as			facility as of 1/16/24 who have			
		sugar 151-200 give 2 units, as, 251-300 give 6 units, 301-350			orders to receive insulin have			
	_	_			potential to be affected.			
		00 give 10 units, for blood sugar nits and call provider.						
	0 ver 400 give 12 ui	ints and can provider.			·These residents were asses	aaad		
	In an interview on 1	1/5/24 at 1:59 PM, the DON			for ordered insulin vials and pe			
		urers recommendations are			to be stored and dated proper			
		ine expiration dates.			the DON on 1/17/24 and show			
	15116 Cu to uctoriiii	spiration autos.			no ill effect. Care plans were	, Su		
	A review of Humal	og lispro insulin KwikPen			reviewed and updated as need	ded		
		Eli Lilly, 2023, indicated				_ Ju.		
		elines include throwing away						
	the insulin pen 28 d				·Temperature logs were aud	lited		
	'				as of 1/17/24 by the DON			
	A current policy titl	led Insulin Administration]			
		d by the DON on 1/8/24 at 10:09						
	_	red insulin should be			1.The measures the facility v	will		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
155512		155512	B. WING		01/08/2024		
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					MAIN ST		
ASCENSION LIVING SACRED HEART VILLAGE					, IN 46710		
AUCENO	TOTA LIVING SACK	LD HEART VILLAGE		AVILLA	., +01 10		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE	
	immediately discard	ded.		take or systems the facility will			
					alter to ensure that the proble		
	2. During an observation and interview on 1/5/24 at 1:27 PM, a temperature log taped to the front of				will be corrected and will not recur.		
					, , , , , , ,		
	the medication refrigerator in the medication					urses will be re-educated by	
	storage room on unit A was reviewed with RN 3.				the DON or designee on Stora	- I	
	The temperature log had readings recorded on 1/1/24 and 1/2/24 with no further entries. RN 3			of Medications and equ		Į.	
					temperature monitoring and		
	indicated temperatures should have been recorded each day and she was unable to				documentation on or before		
	_				1/26/24 or prior to working their next scheduled shift.		
	guarantee the rerigerator temperatures were consistant for safe med storage. Multiple				Hext scrieduled stillt.		
	medications were stored in the refrigerator.				·The policy and procedure		
	medications were stored in the reinigerator.			Storage of Medications and			
	A current policy titled Equipment Temperature			Equipment temperature monitoring		orina	
	Monitoring and documentation dated 5/23				and documentation have beer	•	
	provided by the Director of Nursing (DON) on			reviewed by the IDT and is			
	1/5/24 at 2:47 PM indicated refrigerator			deemed appropriate.			
	temperatures should be documented daily.						
	tomportunites should be declarated daily.						
	3.1-25(j)						
					1.Quality Assurance Plans to	0	
					monitor facility compliance to		
					make sure that corrections are	Э	
					achieved and permanent.		
					·Under the direction of the		
					Quality Assurance and Proces	SS	
					Improvement (QAPI) monthly		
					Committee meeting, the DON or		
					designee will audit 5 random l	ike	
					residents 2 times weekly x 4		
					weeks, then 3 random like		
					residents 2 x weekly x 4 week		
					then 2 random like residents 2		
					weekly for 16 weeks for prop		
					insulin storage and labeling to		
					ensure insulins are stored and		
					labeled correctly. The DON or		
			1		designee will audit all medicat	IOI	I

PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155512		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/08/2024				
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	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 APPROPRIA DEFICIENCY)	DATE			
R 0000				fridges 2 times weekly x 4 week then weekly x 4 weeks, then monthly for 4 months to ensur temperatures are being record per policy. Audits will be submitted and reviewed by the QAPI commit for management of ongoing compliance and will continue upon compliance or greater is achieved for a minimum of 4 continuous weeks. The administrator is respon for ensuring ongoing compliance.	e ded d tee until			
Bldg. 00	Survey. This visit is Residential Complaincluded a Recertific Survey. Complaint IN00424 the allegations are consumptions of the survey dates: January 2024 Facility number: 0000 Residential: 28 Ascension Living S	ary 2, 3, 4, 5 and January 8,	R 0000					
	•	with 410 IAC 16.2-5 in regard tial Licensure Survey and the						

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
15		155512	B. WING			01/08/2024	
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	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION			DEFICIENCY)	-	DATE
	S	emplaint IN00424204. Appleted January 10, 2024					

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