STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	01/08/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Residential Complaint IN00424204. Survey dates: January 2, 3, 4, 5 and January 8, 2024 Facility number: 000404 Provider number: 155512 AIM number: 100290810 Census Bed Type: SNF/NF: 71 Residential: 28 Total: 99 Census Payor Type: Medicare: 1 Medicaid: 80 Other: 18 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 10, 2024	F 0000		
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Beck	RN, DON	01/23/2024

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	accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to 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 postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.			
	Based on observation, interview, and record review the facility failed to ensure privacy was maintained for 2 of 24 residents reviewed (Resident 24, and Resident 32). Findings include: 1) During an observation and interview on 1/2/24 at 9:48 AM, Resident 24's catheter bag partially filled with yellow liquid was visible from his	F 0583	=”” p=””> Preparation and execution of this plan of correction does not constitute Sacred Heart’s admission to or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of	01/26/2024

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	doorway. Qualified Medicine Aide (QMA) 2 indicated Resident 24's catheter bag should be covered. Resident 24's record was reviewed on 1/2/24 at 11:07 AM. Diagnoses included multiple sclerosis, neuromuscular dysfunction of the bladder, and benign prostatic hyperplasia with lower urinary tract symptoms. A review of Resident 24's current quarterly Minimum Data Set (MDS) dated 12/11/23 indicated he had a Basic Interview for Mental Status (BIMS) score of 14 (cognitively intact). The MDS indicated Resident 24 used an indwelling catheter. A review of Resident 24's current care plan titled ...indwelling catheter for diagnosis of neuromuscular bladder ... indicated the resident had a problem of indwelling catheter use, with a goal date of 3/11/24. Interventions included cover catheter bag with a dignity cover. A review of physician orders dated 1/10/19 indicated Resident 24's catheter and drainage bag should be changed as needed based on clinical indicators. In an interview on 1/3/24 at 2:45 PM, the Director of Nursing indicated the catheter bag should have been covered to maintain privacy. A current policy titled Procedure: Catheter Care, Urinary, Last reviewed 12/17, provided by the Director of Nursing on 1/3/24 at 2:45 PM did not indicated the resident's catheter should be covered. 2) During a medication pass observation on 1/4/24		correction is prepared and executed pursuant to Sacred Heart's obligations under federal and state law. F TAG 583 - S/S= D Plan of Correction: 1.Corrective action for residents noted to have been affected by the deficient practice. ·Resident #24 and #32 were assessed by DON on 1/16/24 and showed no ill effect. Care plans have been reviewed and updated as needed. A dignity bag was placed to provide privacy for the resident on 1/16/24. 1.How will the facility identify other residents having the potential to be affected by the same deficient practice? ·All residents residing in the facility as of 1/16/24 have the potential to be affected. ·All nurse computers were audited on 1/16/24 on each unit and found to be in compliance with community policy. ·No other residents residing in the facility as of 1/16/24 have catheters.	

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	at 8:20 AM, Registered Nurse (RN 3) was observed preparing medications for Resident 32. After preparing the medications, RN 3 walked away from the cart leaving it unattended with the computer screen open. Resident 32's protected health information including her name and medications were visible on the screen to individuals passing by. The cart was situated by the dining room with residents and staff passing within visual range of the cart. During an observation on 1/5/24 at 1:21 PM, RN 3 prepared a cup with pills in it and walked away from her cart with her computer screen open leaving resident information visible. The cart was situated in the hallway with staff and residnets passing within visual range of the cart. During an interview on 1/4/24 at 8:55 AM, RN 3 indicated she should have closed her computer screen prior to leaving the medication cart to ensure privacy. Resident 32's record was reviewed on 1/8/24 at 12:29 PM. Diagnoses included Vascular dementia, moderate with psychotic disturbance, anxiety disorder, and hypertensive heart disease without heart failure. A review of Resident 32's current quarterly MDS dated 10/25/23, indicated Resident 32 had a BIMS score of 12 (mild cognitive impairment). A current policy titled Ascension Annual Compliance, dated 2023, provided by the Director of Nursing on 1/8/24 at 11:20 AM indicated staff should not walk away from computers while logged in and the screen should have been locked when the staff member was away from the computer.		1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·The policy and procedure Confidentiality of Information and Quality of life- Dignity has been reviewed by the IDT and is deemed appropriate. ·Nursing staff will be re-educated by the DON or designee on Quality of Life- Dignity and Confidentiality of Information by 1/26/24 1.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. ·Under the direction of the Quality Assurance and Process Improvement (QAPI) monthly Committee meeting, the DON or designee will audit catheter bag coverings, and maintaining confidentiality during med pass 2 times weekly to ensure catheter dignity bags are in place at all times and that confidentiality is maintained during med passes. ·Audits will be submitted and reviewed by the QAPI committee for management of ongoing compliance and will continue until 90% compliance or greater is	

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	3-1(p)(5)		achieved for a minimum of 4 continuous weeks. ·The administrator is responsible for ensuring ongoing compliance. 1.Completion Date: 1/26/24 p="" dir="ltr" role="presentation" quality="" assurance="" plans="" to="" monitor="" facility="" compliance="" make="" sure="" that="" corrections="" are="" achieved="" and="" permanent.<="" p="">p="" dir="ltr" role="presentation" under="" the="" direction="" of="" quality="" assurance="" and="" process="" improvement="" (qapi) ="" 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="presentation" completion="" date:="" 1="" 26="" 24<="" p="">	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:			

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	§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview and record review, the facility failed to ensure the investigation of attempted self-harm for 1 of 3 residents reviewed. (Resident 4). Findings include: In an interview on 1/2/24 at 1:48 PM Resident 4 was observed avoiding eye contact during the interview. Resident 4 did not respond verbally to this writer's greetings and continued to look at the floor. Resident 4's record was reviewed on 1/4/24 at 10:16 AM. Diagnoses included Down Syndrome, anxiety disorder, major depressive disorder, Alzheimer's, unspecified dementia, restlessness and agitation. Resident 4's current quarterly Minimum Data Set (MDS) indicated their Basic Interview for Mental Status (BIMS) score was 1 (severe cognitive impairment). The MDS indicated Resident 4 had not displayed any behaviors. The MDS indicated Resident 4 was able to make themselves	F 0610	=”” p=””> p=”” dir=”ltr” role=”presentation” 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=””> =”” span=””> =”” p=””> Preparation and execution of this plan of correction does not constitute Sacred Heart’s admission to or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of correction is prepared and executed pursuant to Sacred Heart’s obligations under federal	01/26/2024

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	understood and was able to understand others. Resident 4's current care plan entry dated 2/9/23 indicated the resident's family had reported a history of suicidal ideations. The target goal was for the resident to have no suicidal ideations through 11/30/23. Interventions included arranging psychiatric services as needed, 1 to 1 staff visits, monitor moods and monitor effectiveness of antipsychotic medications. Resident 4's current care plan entry dated 5/1/23 indicated the resident had displayed behaviors of refusal of care, refusing medications, being combative with staff during care and difficulty with redirection. The target goal was for Resident 4 to have fewer refusals through 11/30/23. Interventions included review of medications, allow choices, monitor and document behaviors, ask for family input and encourage communication. Resident 4's current care plan entry dated 1/24/20 indicated the resident had a life long history of depression and displayed extreme tearfulness and unrealistic fears. Target goals included attendance of 1 new activity weekly and no increase in depression through 11/29/23. Interventions included 1 to staff visits, encourage socialization, allow choices, allow the resident to select dining room seating and monitor effectiveness of medications. A progress note dated 3/4/23 at 11:23 AM indicated Resident 4 had been found holding their call light cord around their neck. Resident 4 did not respond to questions related to the call light cord being around their neck. A progress note dated 3/4/23 at 11:44 AM		and state law. F TAG 610 - S/S= D Plan of Correction: 1.Corrective action for residents noted to have been affected by the deficient practice. ·Residents #4 was assessed by DON on 1/16/24 and showed no ill effect. Care plans have been reviewed and updated as needed. ·Resident #4 was assessed by Social Services on 1/19/24 and showed no ill effect. Resident #4 will continue to follow up with psych services as needed. 1.How will the facility identify other residents having the potential to be affected by the same deficient practice? ·Other residents residing in the facility as of 1/16/24 who have had unusual occurrences have the potential to be affected. ·No other residents have been identified to have had unusual occurrences as of 1/16/24. 1.The measures the facility will take or systems the facility will alter to ensure that the problem	

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	indicated Resident 4 did not display increased depression symptoms, was pleasant and cooperative and had no thoughts of harming self or thoughts of being better off dead. Resident 4's call light cord was found lying on their bed wrapped loosely numerous times with a loop lying on the bed and wrapped around the bed rail. It was determined Resident 4 most likely got tangled in the call light cord on accident. Resident 4's call light was removed and replaced with a bell. A progress note dated 3/6/23 at 9:33 AM noted as a late entry for 3/4/23 indicated the incident was determined to not be a behavioral incident. 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 around their neck had not been investigated. The DON indicated the event had not been reported to the Indiana Department of Health (IDOH). The DON indicated they did not believe the event was an unusual occurrence. The Assistant Director of Nursing (ADON) indicated Resident 4 had an exceptionally long call light cord. The ADON indicated they did not believe Resident 4 had formulated a plan to harm themselves. The ADON indicated Resident 4 was pleasant, laughing and denied the depression screen question of having thoughts of harming self or thoughts of being better off dead. The DON indicated the facility did not have a policy for suicidal ideation or suicide precautions. A current policy related to reportables dated 12/16 provided by the DON indicated the facility was to report adverse events or unusual occurrences as required by federal or state regulations. 3.1-28(d)		will be corrected and will not recur. ·The Administrator, DON and ADON will be re-educated by the regional nurse consultant or designee on reporting unusual occurrences on or before 1/26/24 or prior to working their next scheduled shift. ·The policy and procedure Unusual Occurrence Reporting has been reviewed by the IDT and is deemed appropriate. 1.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. ·Under the direction of the Quality Assurance and Process Improvement (QAPI) monthly Committee meeting, the DON or designee will evaluate all incidents brought to daily clinical huddle each week to determine if the incidents meet the criteria of unusual occurrence that would require reporting. ·Audits will be submitted and reviewed by the QAPI committee for management of ongoing compliance and will continue until 90% compliance or greater is achieved for a minimum of 4 continuous weeks. ·The administrator is responsible for ensuring ongoing compliance.	

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	3.1-28(e)		1.Completion Date: 1/26/24 ="" p="">\n\np="" dir="ltr" role="presentation" corrective="" action="" for="" residents="" noted="" to="" have="" been="" affected="" by="" the="" deficient="" practice.<="" p="">\np="" dir="ltr" role="presentation" residents="" #4="" was="" assessed="" by="" don="" on="" 1="" 16="" 24="" and="" showed="" no="" ill="" effect. ="" care="" plans="" have="" been="" reviewed="" updated="" as="" needed. <="" p="">\n\np="" dir="ltr" role="presentation" 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="">\n\np="" dir="ltr" role="presentation" how="" will="" the="" facility="" identify="" other="" residents="" having="" potential="" to="" be="" affected="" by="" same="" deficient="" practice?<="" p="">\n\np="" dir="ltr" role="presentation" other="" residents="" residing="" in="" the="" facility="" as="" of=""	

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ASCENSION LIVING SACRED HEART VILLAGE	515 N MAIN ST AVILLA, IN 46710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			quality="" assurance="" and="" process="" improvement="" (qapi) ="" monthly="" committee="" meeting,="" don="" or="" designee="" will="" evaluate="" all="" incidents="" brought="" to="" daily="" clinical="" huddle="" each="" week="" determine="" if="" meet="" criteria="" unusual="" occurrence="" that="" would="" require="" reporting. <="" span="">p="" dir="ltr" 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.<="" span="">p="" dir="ltr" role="presentation" the="" administrator="" is="" responsible="" for="" ensuring="" ongoing="" compliance.<="" span p="" dir="ltr" role="presentation" completion="" date:="" 1="" 26="" 24<="" span="">p="" dir="ltr" role="presentation" how="" will="" the="" facility="" identify="" other="" residents="" having="" potential="" to="" be="" affected="" by="" same="" deficient="" practice?<="" p="">p="" dir="ltr" role="presentation"	

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			other="" residents="" residing="" in="" the="" facility="" as="" of="" 1="" 16="" 24="" who="" have="" had="" unusual="" occurrences="" 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="" 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="" has="" been="" reviewed="" by="" idt="" is="" deemed="" appropriate.<="" p="">" p="" dir="ltr" role="presentation" quality="" assurance="" plans="" to="" monitor="" facility=""	

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			compliance="" make="" sure="" that="" corrections="" are="" achieved="" and="" permanent.<="" p=""> p="" dir="ltr" role="presentation" under="" the="" direction="" of="" quality="" assurance="" and="" process="" improvement="" (qapi) ="" committee,="" don="" or="" designee="" will="" evaluate="" all="" incidents="" brought="" to="" daily="" clinical="" huddle="" each="" week="" determine="" if="" meet="" criteria="" unusual="" occurrence="" that="" would="" require="" reporting. <="" p=""> p="" dir="ltr" role="presentation" completion="" date:="" 1="" 26="" 24<="" p="">	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review the facility failed to ensure MD orders were followed for cervical spine fracture management in 1 of 24 resident reviewed for quality of care. (Resident 181). Findings include:	F 0684	=" p=""> Preparation and execution of this plan of correction does not constitute Sacred Heart's admission to or agreement with the facts alleged or conclusions	01/26/2024

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	During an observation on 1/2/24 at 1:05 PM, Resident 181 was sitting in his recliner watching television. The resident's cervical collar (C-collar) was in a chair across the room. In an interview on 1/2/24 at 1:08 PM, Resident 181 indicated he was supposed to wear the C-collar, but the staff never puts the C-collar back on. Resident 181's record was reviewed on 1/7/24 at 2:47 PM. Diagnoses included a fall from a motorized mobility scooter resulting in C2 odontoid process fracture, bilateral hearing loss, and mild cognitive impairment of unknown origin. Resident 181's current admission Minimum Data Set (MDS), dated 12/26/23, indicated his Basic Interview for Mental Status (BIMS) score was 10 (moderate cognitive impairment). The MDS indicated in the last month prior to admission he had a fall with a related fracture. The MDS indicated the resident required supervision/assistance for transfers and ambulation and used a walker or manual wheelchair. The MDS indicated he was receiving occupational and physical therapy. Resident 181's current Care plan, dated 6/26/23, titled Non-compliance with Care and Orders indicated the resident refused to wear his C-collar at times, with a goal he would not have an injury when refusing to wear the C-collar. Interventions included documenting the resident's refusal to wear his C-collar. A physician orders dated 12/26/23 indicated Resident 181's C-collar was to be worn at all times. There was no indication in the nursing progress		set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of correction is prepared and executed pursuant to Sacred Heart's obligations under federal and state law. F TAG 684- S/S= D Plan of Correction: 1.Corrective action for residents noted to have been affected by the deficient practice. ·Residents #181 was assessed by the DON on 1/16/24 and showed no ill effect. Care plans have been reviewed and updated as needed. 1.How will the facility identify other residents having the potential to be affected by the same deficient practice? ·All residents residing in the facility as of 1/16/24 that require a brace to be applied have the potential to be affected. ·Residents were evaluated to ensure the resident was wearing a brace as ordered. If a resident is found to not have a brace on as ordered brace will be applied and the resident will be assessed for any adverse effects. Care plans will be reviewed and updated as	

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	notes dated 1-1-24 through 1-3-24 the resident 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 indicated Resident 181 was to wear his C-collar when he was up walking around. After a request to check the orders, LPN 6 indicated she was incorrect, and the resident was to have the C-collar on at all times. LPN 6 went to Resident 181's room and immediately placed the C-collar on the resident. In an interview on 1/8/23 at 9:26 AM, the DON indicated Resident 181 was to wear his C-collar at all times. In an interview on 1/8/23 at 9:26 AM, the DON indicated the facility had no policy for ensuring medical devices were in place. No policy was provided by survey exit. 3.1-37		needed. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·All direct care licensed nurses and CNAs will be re-educated by DON or designee on ensuring braces are applied and removed per physician order on or before 1/19/24 or prior to working their next scheduled shift. ·The policy and procedure Health Care Provider Orders has been reviewed by the IDT and is deemed appropriate. 1.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. ·Under the direction of the Quality Assurance and Process Improvement (QAPI) monthly Committee meeting, the DON or 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 ordered. ·Audits will be submitted and reviewed by the QAPI committee	

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			for management of ongoing compliance and will continue until 90% compliance or greater is achieved for a minimum of 4 continuous weeks. ·The administrator is responsible for ensuring ongoing compliance. 1.Completion Date: 1/26/24	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review the facility failed to ensure fall precaution interventions were made available to direct care staff members for 1 of 2 residents reviewed (Resident 15). This resulted in an injury from a fall that required emergency department intervention for Resident 15. Findings include: On 1/2/24 at 4:00 PM the facility reported Resident 15 had experienced a fall on 1/1/24 at 4:30 PM. The fall resulted in a lip laceration that required sutures. Resident 15's record was reviewed on 1/5/24 at 9:30 AM. Diagnoses included Alzheimer's, major depressive disorder, dementia, restless leg	F 0689	=”” p=””> Preparation and execution of this plan of correction does not constitute Sacred Heart’s admission to or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of correction is prepared and executed pursuant to Sacred Heart’s obligations under federal and state law. =”” p=”>	01/26/2024

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	syndrome and contractures to the left hand. A review of Resident 15's most recent annual Minimum Data Set (MDS) dated 8/23/23 indicated their Basic Interview for Mental Status (BIMS) score was 0 (severe cognitive loss). Resident 15 required maximum assistance to roll left and right in the bed. The resident was dependent on staff to change position from lying in bed to sitting on the side of the bed. The resident was dependent on staff to change position from sitting on the side of the bed to lying in the bed and was dependant for 2 assist with sitting balance. Resident 15 was dependent on staff for transfers from a bed to a chair and from a chair to a bed. A physician orders dated 9/20/21 indicated Resident 15 was to have a Broda (an assistive seating device for fall prevention) chair for proper positioning. Resident 15's current care plan entry dated 4/22/14, revised 11/13/23 indicated the resident was at risk for falls or fall related injuries. The target goal was reduced risk for falls and fall related injuries through 2/2/24. An intervention dated 2/24/20 indicated Resident 15 was to be seated in a reclined position in their Broda chair at all times except during meals. An intervention dated 5/5/20 indicated staff were to assist with all transfers. An intervention dated 1/1/24 indicated Resident 15 was not to be seated on the side of the bed until ready for transfer. Interventions did not specify the assistance of 2 staff members for resident transfer. The interventions did not include a mechanical lift for resident transfer. Resident 15's undated care card (guide to CNA care) for direct care staff members indicated the resident was at risk for falls. Resident 15 required		F TAG 689 - S/S= D ="" p="">"> Plan of Correction: ="" p="">"> 1.Corrective action for residents noted to have been affected by the deficient practice. ·Resident #15 was assessed by DON on 1/16/24 and showed no further ill effect. Care plans have been reviewed and updated as needed. ="" p="">"> 1.How will the facility identify other residents having the potential to be affected by the same deficient practice? ="" p="">"> ·Other residents residing in the facility as of 1/16/24 who are dependent on staff for positioning and transfers have the potential to be affected. ·These residents were assessed for appropriate fall interventions by ADON on 1/17/24. Care plans were reviewed and updated as needed. ="" p="">"> ·A care card audit was completed for residents with fall interventions by the ADON on	

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	assistance from 1 staff member for bed mobility, required a Broda chair, required a mechanical lift for transfers and was not to be placed in a sitting position on the side of the bed until ready for transfer due to the resident having poor trunk strength (dated 1/1/24). A progress note dated 1/1/24 at 8:04 PM indicated Resident 15 had a witnessed fall at 4:30 PM. The note indicated staff had been preparing Resident 15 to take a shower and had placed the resident up on the bed. The note indicated Resident 15 slid to the left, hit the bedside table splitting her lip. An Interdisciplinary Team (IDT) progress note dated 1/2/24 at 1:19 PM indicated a Certified Nurse Aide (CNA) placed Resident 15 on the side of the bed and turned away to remove items from the closet. The note indicated Resident 15 had poor trunk control. A Resident at Risk Review dated 11/22/23 indicated Resident 15 had a fall risk score of 22 (moderate risk). The review indicated Resident 15 was bed/chair bound and required extensive staff assistance for activities of daily living (bathing, dressing, getting in or out of bed or chair, eating and toileting). Resident 15 required the assistance of 2 staff members for transfers. An Indiana State Department of Health Survey Report dated 1/2/24 indicated Resident 15 had experienced a fall on 1/1/24 at 4:30 PM. The report indicated a CNA placed Resident 15 on the side of the bed and turned away to remove items from the closet. Resident 15 slid to the side and hit their lip on the bedside table. The report indicated Resident 15 had a BIMS score of 0, used a Broda chair for positioning and required staff assistance for transfers.		1/17/24 and was updated as needed. ="" p=""> 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ="" p=""> ·All CNA's will be re-educated by DON or designee on fall prevention on or before 1/26/24 ="" p=""> ·The policy and procedure Fall Prevention has been reviewed by the IDT and is deemed appropriate. ="" p=""> 1.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. ·Under the direction of the Quality Assurance and Process Improvement (QAPI) monthly Committee meeting, the ADON or designee will audit transfers for 3 residents who are dependent on staff for transfers each week to ensure fall interventions are implemented at the time of transfer. ·Audits will be submitted and	

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	In an interview on 1/5/24 at 12:10 PM the Director of Nursing (DON) indicated according to MDS assessments, Resident 15 was not physically capable of sitting on the side of the bed alone and did not fall during a transfer. The DON indicated Resident 15 was being prepared for transfer to the shower chair when the fall occurred. In an interview on 1/5/24 at 1:03 PM Qualified Medication Aide (QMA) 4 indicated on 1/1/24 Resident 15 had a witnessed fall from the bed to the floor. A CNA had positioned the resident in a sitting position on the side of the bed and the CNA then turned away. The CNA who left the resident sitting on the side of the bed unattended was from a staffing agency. Resident 15 slid from the bed hitting the bedside table before falling to the floor, and should have not been left sitting on the side of the bed unattended. QMA 4 indicated the resident's care card had been updated to include not leaving the resident sitting on the side of the bed unattended on 1/1/24 after the resident fell. QMA 4 indicated Resident 15 was ready for transfer, but another CNA had left the room to retrieve a shower chair. A current policy dated 12/17 provided by the DON indicated the documentation of identified interventions should be maintained in the clinical record and available to the direct care associates. 3.1-45(a)		reviewed by the QAPI committee for management of ongoing compliance and will continue until 90% compliance or greater is achieved for a minimum of 4 continuous weeks. ·The administrator is responsible for ensuring ongoing compliance. 1.Completion Date: 1/26/24 ="" p="">"> p="" dir="ltr" role="presentation" corrective="" action="" for="" residents="" noted="" to="" have="" been="" affected="" by="" the="" deficient="" practice.<="" p="">"> p="" dir="ltr" role="presentation" resident="" #15="" was="" assessed="" by="" don="" on="" 1="" 16="" 24="" and="" showed="" no="" further="" ill="" effect. ="" care="" plans="" have="" been="" reviewed="" updated="" as="" needed. <="" p="">"> p="" dir="ltr" role="presentation" how="" will="" the="" facility="" identify="" other="" residents="" having="" potential="" to="" be="" affected="" by="" same="" deficient="" practice?<="" p="">"> p="" dir="ltr" role="presentation" other="" residents="" residing="" in="" the="" facility="" as="" of=""	

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			1="" 16="" 24="" who="" are="" dependent="" on="" staff="" for="" positioning="" and="" transfers="" have="" potential="" to="" be="" affected. p="" dir="ltr" role="presentation" a="" care="" card="" audit="" was="" completed="" for="" residents="" with="" fall="" interventions="" by="" the="" adon="" on="" 1="" 17="" 24="" and="" updated="" as="" needed.<="" p=""> 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" all="" cna's="" will="" be="" re-educated="" by="" don="" or="" designee="" on ="" fall="" prevention="" on="" before="" 1="" 26="" 24<="" p=""> p="" dir="ltr" role="presentation" the="" policy="" and="" procedure="" fall="" prevention="" has="" been="" reviewed="" by="" idt="" is="" deemed="" appropriate.<="" p="">	

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			p="" dir="ltr" role="presentation" quality="" assurance="" plans="" to="" monitor="" facility="" compliance="" make="" sure="" that="" corrections="" are="" achieved="" and="" permanent.<="" p=""> p="" dir="ltr" role="presentation" under="" the="" direction="" of="" quality="" assurance="" and="" process="" improvement="" (qapi) ="" committee,="" adon="" or="" designee="" will="" audit="" transfers="" for="" 3="" residents="" who="" are="" dependent="" on="" staff="" each="" week="" to="" ensure="" fall="" interventions="" implemented="" at="" time="" transfer. <="" p=""> p="" dir="ltr" role="presentation" completion="" date:="" 1="" 26="" 24<="" p="">	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's			

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	clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review the facility failed to ensure tube feeding formula was labeled and dated for 1 of 1 resident reviewed (Resident 71). Findings include: During an observation on 1/2/24 at 9:37 AM Resident 71 was observed sitting in the recliner in her room with a translucent bag of about an inch of tan liquid. A tubing engaged in a tube feeding pump was attached to Resident 71's gastric tube. The bag and tubing were not dated or labeled with the formula type or orders for administration. During an observation on 1/4/24 at 3:02 PM, Resident 71 was observed sitting in the recliner in her room visiting with a guest. A tube feeding bag was observed with about 1/2 inch of tan liquid in the tubing draped over the top of the pole holding the tube feeding pump. No date or label was seen on the bag. Resident 71's record was reviewed on 1/4/24 at 3:10 PM. Diagnoses included amyotrophic lateral sclerosis, progressive bulbar palsy, and dysphagia, oropharyngeal phase.	F 0693	=”” p=””> Preparation and execution of this plan of correction does not constitute Sacred Heart’s admission to or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of correction is prepared and executed pursuant to Sacred Heart’s obligations under federal and state law. F TAG 693 - S/S= D Plan of Correction: 1.Corrective action for residents noted to have been affected by the deficient practice. ·Resident #71 was assessed by the DON on 1/17/24 and showed no ill effect. Care plans have been reviewed and updated as needed. 1.How will the facility identify	01/26/2024

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	A review of Resident 71's significant change Minimum Data Set (MDS) dated 9/26/23 indicated her Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated the resident received a tube feeding. A review of physician orders dated 11/28/23 indicated Jevity 1.5 should be administered at 60 ml per hour via kangaroo pump starting at 10:00 PM and stopping at 10:00 AM. In an interview on 1/5/24 at 9:32 AM, the Director of Nursing (DON) indicated tube feeding bags and tubing should be changed daily, labeled, and dated. She indicated she was unable to confirm this was being done since the bag and tubing were not labeled and dated. A current policy titled Procedure: Enteral Tube Feeding Via Continuous Pump dated 1/24 provided by the DON on 1/5/24 at 11:28 AM indicated the bag should be labeled with initials, date, and time the formula was hung and initials that the label was checked against the order. 3.1-44(a)(2)		other residents having the potential to be affected by the same deficient practice? ·Other residents residing in the facility as of 1/16/24 who have G-tubes have the potential to be affected. ·There are no other residents residing in the facility that have g-tube feedings as of 1/16/24. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·Nurses will be re-educated by the DON or designee on tube feeding procedure for enteral tube feeding via continuous pump on or before 1/26/24 or prior to working 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	

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			achieved and permanent. ·Under the direction of the Quality Assurance and Process Improvement (QAPI) monthly Committee meeting, the DON or designee will audit all residents with tube feedings to ensure date and label are present on tube feeding bags 2 times weekly to ensure tube feeding bags are labeled and dated. ·Audits will be submitted and reviewed by the QAPI committee for management of ongoing compliance and will continue until 90% compliance or greater is achieved for a minimum of 4 continuous weeks. ·The administrator is responsible for ensuring ongoing compliance. 1.Completion Date: 1/26/24 ="" p="">`  `p="" dir="ltr" role="presentation" corrective="" action="" for="" residents="" noted="" to="" have="" been="" affected="" by="" the="" deficient="" practice.<="" p="">` `p="" dir="ltr" role="presentation" resident="" #71="" was="" assessed="" by="" the="" don="" on="" 1="" 17="" 24="" and="" showed="" no="" ill="" effect. ="" care="" plans="" have="" been="" reviewed="" updated="" as=""	

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			needed. <="" p="">

p="" dir="ltr" role="presentation" how="" will="" the="" facility="" identify="" other="" residents="" having="" potential="" to="" be="" affected="" by="" same="" deficient="" practice?<="" p="">

p="" dir="ltr" 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="">

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			pump="" has="" been="" reviewed="" by="" idt="" is="" deemed="" appropriate.<="" p=""> p="" dir="ltr" role="presentation" quality="" assurance="" plans="" to="" monitor="" facility="" compliance="" make="" sure="" that="" corrections="" are="" achieved="" and="" permanent.<="" p=""> p="" dir="ltr" role="presentation" under="" the="" direction="" of="" quality="" assurance="" and="" process="" improvement="" (qapi) ="" committee,="" don="" or="" designee="" will="" audit="" all="" residents="" with="" tube="" feedings="" to="" ensure="" date="" label="" are="" present="" on="" feeding="" bags="" 2="" times="" weekly="" labeled="" dated. <="" p=""> p="" dir="ltr" role="presentation" completion="" date:="" 1="" 26="" 24<="" p="">	
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with			

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	professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure physician orders were followed and safe handling of respiratory equipment was completed for 4 of 24 residents reviewed. (Resident 9, Resident 24, Resident 36, and Resident 68). Findings include: 1) During an observation on 1/2/24 at 1:35 PM, Resident 9 was laying in her bed. Her nasal cannula (NC) oxygen tubing (a lightweight tube split into two prongs on one end and placed in the nostrils used to deliver supplemental oxygen) was attached to her oxygen condenser (a medical device that gives you extra oxygen) laying on the oxygen condenser unbagged. The oxygen condenser flow meter was turned to 2 liters per minutes (LPM) delivering oxygen via the NC. Her oxygen condenser was positioned at the upper right side of her bed. The resident's portable oxygen condenser (a lightweight transportable oxygen condenser), not in use at that time, was sitting on the floor with NC oxygen tubing attached. The NC oxygen tubing extended from the portable oxygen unit and laid on the chair unbagged. The oxygen tubings attached to Resident 9's oxygen condenser and portable oxygen condenser were not labeled with the time and date the tubing was changed. During an interview on 1/3/24 at 1:41 PM, Resident 9 indicated she wore oxygen. During an observation on 1/2/24 at 1:41 PM, Licensed Practical Nurse (LPN) 5 put the NC	F 0695	=”” p=””> Preparation and execution of this plan of correction does not constitute Sacred Heart’s admission to or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of correction is prepared and executed pursuant to Sacred Heart’s obligations under federal and state law. F TAG 695 - S/S= E Plan of Correction: 1.Corrective action for residents noted to have been affected by the deficient practice. ·Residents #9, 24, 36, 68 were assessed by DON on 1/17/24 and showed no ill effect. Care plans have been reviewed and updated as needed. ·Oxygen utilization was reviewed with the provider for resident #36 and #68 and the order for oxygen use was discontinued, care plan updated. 1.How will the facility identify other residents having the potential to be affected by the	01/26/2024

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	oxygen tubing on Resident 9. Resident 9's record was reviewed on 1/3/24 at 2:20 PM. Diagnoses included chronic obstructive pulmonary disease (COPD), obstructive sleep apnea (OSA), and morbid obesity, Resident 9's current significant change in status Minimum Data Set (MDS) assessment, dated 10/31/23, indicated her Basic Interview of Mental Status (BIMS) score was 8 (mild cognitive impairment). The MDS indicated she had a lower extremity impairment on one side and used a manual wheelchair. The MDS indicated the resident required maximal assistance from staff to roll right to left and lying to sitting on the side of the bed and was dependent on staff to bed-to chair transfers. The MDS indicated the resident had shortness of breath or trouble breathing when laying flat and wore oxygen after arriving to the facility. Resident 9's current care plan titled "Impaired Gas Exchange" indicated the resident was dependent on oxygen related to COPD and OSA with a goal to be free from cardiac symptoms of respiratory distress. Interventions included to monitor oxygen flow rate and change tubing and bubblers per protocol or as ordered. A physician orders dated 10/19/23 indicated Resident 9's oxygen was to be at 2 LPM via NC and may be titrated to keep oxygen sats above 90%. A physician orders dated 6/19/23 indicated Resident 9's oxygen tubing was to be changed weekly on 3rd shift. Resident 9's Medication Administration Record		same deficient practice? ·Other residents residing in the facility as of 1/16/24 who have an order for oxygen therapy or nebulizer treatments have the potential to be affected. ·These residents were assessed by the DON on 1/17/24 and showed no ill effect. Care plans were reviewed and updated as needed. ·All oxygen and nebulizer treatment tubing was evaluated to ensure proper storage and dates of tubing change were indicated on 1/17/24. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·Nursing staff will be re-educated by the DON or designee on respiratory care- prevention of infection, proper changing/dating of tubing and cleaning and storage of nebulizer equipment on or before 1/26/24 or prior to working their next scheduled shift. ·The policy and procedure Respiratory Care- prevention of infection has been reviewed by the	

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	indicated the oxygen tubing was changed at 5:00 AM on 12/4/23, 12/10/23, 12/17/23, 12/24/23 and 12/31/23 indicating the oxygen tubing for the oxygen condenser and portable oxygen condenser was last changed on Sunday 12/31/23 at 5:00 AM but not labeled.2) During an observation and interview on 1/2/24 at 9:40 AM, Resident 24 was observed lying in bed with a nasal cannula placed in his nostrils, attached to an oxygen concentrator beside the bed. The oxygen concentrator was turned on and set to deliver 0 liters of oxygen per minute. Qualified Medicine Aide (QMA) 2 indicated the oxygen should have been set at 2 liters per minute and she did not know why it had been turned down to zero. QMA 2 indicated she was unable to verify when the oxygen tubing had been changed because she was unable to find a date on the tubing. Resident 24's record was reviewed on 1/4/24 at 12:56 PM. Diagnoses included multiple sclerosis, sleep apnea, unspecified, and personal history of pulmonary embolism. A review of Resident 24's current quarterly Minimum Data Set (MDS) dated 12/11/23 indicated he had a Basic Interview for Mental Status (BIMS) score of 14 (cognitively intact). The MDS indicated Resident 24 used oxygen. A review of a care plan titled ...has pneumonia, undated and labeled inactive, included an approach indicating oxygen should be administered as ordered. No current care plan pertaining to oxygen use was available for review. A review of physician orders dated 11/6/23 indicated oxygen should be delivered at 2 liters per minute by nasal cannula. A physician's order dated 11/7/23 indicated oxygen tubing should be		IDT and is deemed appropriate. 1.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. ·Under the direction of the Quality Assurance and Process Improvement (QAPI) monthly Committee meeting, the DON or designee will audit 3 residents with orders for oxygen therapy or nebulizer treatments 2 x's weekly to ensure physician orders are followed and safe handling of O2 and nebulizer equipment was completed. ·Audits will be submitted and reviewed by the QAPI committee for management of ongoing compliance and will continue until 90% compliance or greater is achieved for a minimum of 4 continuous weeks. ·The administrator is responsible for ensuring ongoing compliance. 1.Completion Date: 1/26/24	

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	changed weekly. In an interview on 1/3/24 at 2:45 PM, the Director of Nursing (DON) indicated oxygen should be administered as ordered and tubing should be changed weekly and dated. 3) During an observation and interview on 1/3/24 at 10:52 AM, A respiratory treatment mask and tubing were observed lying on Resident 36's dresser unbagged and undated. Resident 36 was seated in his wheelchair in his room and was not using oxygen. He indicated he had not used oxygen in a while. Resident 36's record was reviewed on 1/3/24 at 10:52 AM. Diagnoses included chronic obstructive pulmonary disease, personal history of pulmonary embolism, hypoxemia, and dependence on supplemental oxygen. A review of Resident 36's current quarterly Minimum Data Set (MDS) dated 12/13/23 indicated his Basic Interview for Mental Status (BIMS) score was 14 (cognitively intact). A review of Resident 36's care plan, dated 1/22/21, labeled inactive, included an approach to administer oxygen as ordered for shortness of breath. No current care plans mentioning oxygen were available for review. A review of current physician's orders dated 2/14/22 indicated oxygen should be administered at a rate of 2 liters per minute via nasal cannula for shortness of breath. An additional current physician's order dated 2/14/22 indicated oxygen should be administered at a rate of 2 liters per minute via nasal cannula as needed for oxygen saturations less than 90 percent and shortness of			

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	breath. 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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	to keep sats greater than or equal to 90 percent, may titrate. In a review of the Medication Administration Record for January 2024, an order dated 2/24/23, indicating supplemental oxygen via nasal cannula at 3 liters to keep saturations greater than or equal to 90 percent, may titrate, was checked as given on 1/1/24, 1/2/24, and 1/3/24. A review of Resident 68's current care plan titled ...at risk for respiratory distress indicated the resident had a problem of shortness of breath, with a goal date of 1/9/24. Interventions included maintain oxygen administration device as ordered. A review of progress notes dated 1/4/24 at 2:44 PM indicated Resident 68 was using continuous oxygen at 3 liters per minute. In an interview on 1/3/24 at 2:45 PM, the DON indicated respiratory tubing should be bagged when not in use and oxygen orders should be followed. A current policy titled Procedure: Administering Medications Through a Small Volume Nebulizer dated 1/24 provided by the DON on 1/3/24 at 2:45 PM indicated respiratory equipment should be cleaned after use and stored in a plastic bag with the resident's name and date. The policy indicated the equipment should be changed every seven days. A current policy titled Procedure: Oxygen Administration dated 12/22 provided by the DON on 1/3/24 at 2:45 PM indicated oxygen tubing should be labeled and dated. 3.1-47(a)(6)			

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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 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). Findings include: 1. During an observation and interview on 1/5/24 at 1:21 PM, medication storage was reviewed with	F 0761	=”” p=””> Preparation and execution of this plan of correction does not constitute Sacred Heart’s admission to or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of correction is prepared and	01/26/2024

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	Registered Nurse (RN) 3. A lispro insulin pen was in the top drawer of the cart with an open date of 12/1/23. The pen was in a plastic bag with a printed label indicating it was for Resident 16. RN 3 indicated the insulin was expired and should have been pulled from the cart and replaced with a new pen. Resident 16's record was reviewed on 1/8/24 at 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 change Minimum Data Set (MDS) dated 11/28/23 indicated her Basic Interview for Mental Status (BIMS) score was 6 (cognitively impaired). The MDS indicated insulin was given during the reference period. A review of physician orders dated 11/21/23 indicated insulin lispro was to be given subcutaneously according to a sliding scale as follows: For blood sugar 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351-400 give 10 units, for blood sugar over 400 give 12 units and call provider. In an interview on 1/5/24 at 1:59 PM, the DON indicated manufacturers recommendations are followed to determine expiration dates. A review of Humalog lispro insulin KwikPen instructions for use, Eli Lilly, 2023, indicated manufacturers guidelines include throwing away the insulin pen 28 days after opening. A current policy titled Insulin Administration dated 6/17 provided by the DON on 1/8/24 at 10:09 AM indicated expired insulin should be		executed pursuant to Sacred Heart's obligations under federal and state law. F TAG 761- S/S= D Plan of Correction: 1.Corrective action for residents noted to have been affected by the deficient practice. ·Residents #33 was assessed by DON on 1/17/24 and showed no ill effect. Care plans have been reviewed and updated as needed. 1.How will the facility identify other residents having the potential to be affected by the same deficient practice? ·Other residents residing in the facility as of 1/16/24 who have orders to receive insulin have the potential to be affected. ·These residents were assessed for ordered insulin vials and pens to be stored and dated properly by the DON on 1/17/24 and showed no ill effect. Care plans were reviewed and updated as needed. ·Temperature logs were audited as of 1/17/24 by the DON 1.The measures the facility will	

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	immediately discarded. 2. During an observation and interview on 1/5/24 at 1:27 PM, a temperature log taped to the front of the medication refrigerator in the medication storage room on unit A was reviewed with RN 3. The temperature log had readings recorded on 1/1/24 and 1/2/24 with no further entries. RN 3 indicated temperatures should have been recorded each day and she was unable to guarantee the rerigerator temperatures were consistant for safe med storage. Multiple medications were stored in the refrigerator. A current policy titled Equipment Temperature Monitoring and documentation dated 5/23 provided by the Director of Nursing (DON) on 1/5/24 at 2:47 PM indicated refrigerator temperatures should be documented daily. 3.1-25(j)		take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·Nurses will be re-educated by the DON or designee on Storage of Medications and equipment temperature monitoring and documentation on or before 1/26/24 or prior to working their next scheduled shift. ·The policy and procedure Storage of Medications and Equipment temperature monitoring and documentation have been reviewed by the IDT and is deemed appropriate. 1.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent. ·Under the direction of the Quality Assurance and Process Improvement (QAPI) monthly Committee meeting, the DON or designee will audit 5 random like residents 2 times weekly x 4 weeks, then 3 random like residents 2 x weekly x 4 weeks, then 2 random like residents 2 x weekly for 16 weeks for proper insulin storage and labeling to ensure insulins are stored and labeled correctly. The DON or designee will audit all medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	01/08/2024

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

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			fridges 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly for 4 months to ensure temperatures are being recorded per policy. ·Audits will be submitted and reviewed by the QAPI committee for management of ongoing compliance and will continue until 90% compliance or greater is achieved for a minimum of 4 continuous weeks. ·The administrator is responsible for ensuring ongoing compliance. 1.Completion Date: 1/26/24	
R 0000 Bldg. 00	This visit included a State Residential Licensure Survey. This visit included the Investigation of Residential Complaint IN00424204. This visit included a Recertification and State Licensure Survey. Complaint IN00424204 - No deficiencies related to the allegations are cited. Survey dates: January 2, 3, 4, 5 and January 8, 2024 Facility number: 000404 Residential: 28 Ascension Living Sacred Heart Village was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the	R 0000		

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	Investigation of Complaint IN00424204. Quality review completed January 10, 2024			