| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155512 | A. BUILDING -- B. WING | 01/29/2024 |

| 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 |
|---|---|---|---|---|
| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 01/29/24<br><br>Facility Number: 000404<br>Provider Number: 155512<br>AIM Number: 100290810<br><br>At this Emergency Preparedness survey, Ascension Living Sacred Heart Village was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has 133 certified beds. At the time of the survey, the census was 69.<br><br>Quality Review completed on 01/31/24 | E 0000 | | |
| E 0015<br>SS=C<br>Bldg. -- | 403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1)<br>Subsistence Needs for Staff and Patients<br>§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)<br><br>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Patricia Ward | HFA Executive Director | 02/15/2024 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155512 | A. BUILDING -- B. WING | 01/29/2024 |

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

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| | section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:<br><br>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:<br>(i) Food, water, medical and pharmaceutical supplies<br>(ii) Alternate sources of energy to maintain the following:<br>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(B) Emergency lighting.<br>(C) Fire detection, extinguishing, and alarm systems.<br>(D) Sewage and waste disposal.<br><br>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.<br>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:<br>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:<br>(A) Food, water, medical, and pharmaceutical supplies.<br>(B) Alternate sources of energy to maintain the following:<br>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(2) Emergency lighting. | | | |

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|---|---|---|---|
| | 155512 | A. BUILDING -- B. WING | 01/29/2024 |

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

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| | (3) Fire detection, extinguishing, and alarm systems.<br>(C) Sewage and waste disposal.<br>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on records review with the Maintenance Director on 01/29/24 at 10:50 a.m., the subsistence needs documentation for the emergency preparedness program was incomplete. Documentation of a policy to protect residents from extreme temptures could not be found. Based on interview at the time of records review, the Maintenance Director stated there was not an extreme temptures policy to protect resident health and safety.<br><br>This finding was reviewed with the Administrator and Maintenance Director during the exit conference. | E 0015 | Plan of Correction<br>Ascension Living Sacred Heart Village<br>SURVEY EXIT DATE 1/29/2024<br>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.<br>E 015 S/S = C<br><br>Plan of Correction:<br>1. Corrective action for residents noted to have been affected by the deficient practice.<br>¿ No Residents were affected. Extreme Heat/Cold Policies have been reviewed and updated as needed. (See Attached Documentation)<br>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>¿ Other residents residing in the facility as of 1/29/2024 had the potential to be affected.<br>¿ These policies were updated to | 02/20/2024 |

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| | | | ensure all residents were safe and issue addressed.<br><br>3. The measures the facility will take or systems the facility will alter to ensure<br>that the problem will be corrected and will not recur.<br>¿ All staff will be re-educated by the Maintenance Director or designee<br>on the updated policy of Extreme Heat/Cold procedures on or before 2/20/2024 or prior to working their next scheduled shift.<br>¿ The policy and procedure Extreme Heat/Cold has been reviewed by the<br>IDT and is deemed appropriate.<br><br>4. Quality Assurance Plans to monitor facility compliance to make sure that<br>corrections are achieved and permanent.<br>¿ Under the direction of the Quality Assurance and Process Improvement<br>(QAPI) Committee, the Maintenance Director or designee will audit all<br>Emergency Management Binders and insert the Updated procedure for<br>Extreme Heat/Cold<br>¿ Audit will be submitted and reviewed by the QAPI committee for<br>management of ongoing compliance and will continue until | |

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

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|---|---|---|---|---|
| | | | otherwise determined by QAPI committee. ¿ The administrator is responsible for ensuring ongoing compliance. Completion Date: 2/20/2024 | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification (LSC) and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 01/29/24<br><br>Facility Number: 000404<br>Provider Number: 155512<br>AIM Number: 100290810<br><br>At this LSC survey, Ascension Living Sacred Heart Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, LSC, Chapter 19, existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detector in the resident rooms. the facility is partly protected by a type II EES 200 kW diesel powered generator. The facility has a capacity of 133 and had a census of 69 at the time of this survey.<br><br>Quality Review completed on 01/31/24 | K 0000 | | |

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| | 155512 | A. BUILDING 01<br>B. WING | 01/29/2024 |

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| ASCENSION LIVING SACRED HEART VILLAGE | 515 N MAIN ST<br>AVILLA, IN 46710 |

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| K 0321<br>SS=E<br>Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>Based on observation and interview, the facility failed to ensure 1 of 1 E-19 storage rooms with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 30 | K 0321 | Plan of Correction<br>Ascension Living Sacred Heart Village<br>1/29/2024<br>Preparation and execution of this | 02/20/2024 |

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| | 155512 | A. BUILDING 01<br>B. WING | 01/29/2024 |

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| ASCENSION LIVING SACRED HEART VILLAGE | 515 N MAIN ST<br>AVILLA, IN 46710 |

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| | residents in the one smoke compartment.<br><br>Findings include:<br><br>Based on observation during a tour of the facility with Maintenance Director on 01/29/24 at 1:38 p.m., room E-19 was being used as a storage room containing over 20 boxes of supplies and clothing, was greater than 50 square, therefore making the room a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing.<br><br>The finding was reviewed with the Administrator and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | plan of correction does not constitute Sacred Heart Village 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 Village Obligations under federal and state law.<br><br>K TAG -321<br>S/S = E<br>Plan of Correction:<br>1. Corrective action for the 30 residents who had the potential to be affected by the deficient practice.<br>¿ There were no Residents affected by using E-19 as a storage room on 1/29/2024.<br><br>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>¿ Other residents residing in the same facility as of 1/29/2024 were not affected.<br>¿ EVS Director audited all empty rooms in each hall to ensure that no other rooms were being used as storage. | |

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| ASCENSION LIVING SACRED HEART VILLAGE | 515 N MAIN ST<br>AVILLA, IN 46710 |

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| | | | 3. The measures the facility will take or systems the facility will alter to ensure<br>that the problem will be corrected and will not recur.<br>¿ Inservice will be done for all staff, to re-educate on EVS process that no<br>empty rooms can be used as storage without prior approval from the<br>EVS Director or Designee. See attached Inservice sheet.<br>¿ EVS Director will check 3 empty rooms in each hall weekly to ensure<br>compliance. This will be recorded in TELS during room temperature checks.<br>¿ The K Tag 321 has been reviewed by the QAPI committee and is aware of the regulation.<br><br>4. Quality Assurance Plans to monitor facility compliance to make sure that<br>corrections are achieved and permanent.<br>¿ Under the direction of the Quality Assurance and Process Improvement<br>(QAPI) Committee, the Maintenance Director will bring a list of any<br>rooms found to be non-compliant for storage to the QAPI committee for review and discussion.<br>¿ The administrator is responsible for ensuring ongoing compliance. | |

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|---|---|---|---|---|
| | | | 5. Completion Date:2/20/2024 | |
| K 0361<br>SS=E<br>Bldg. 01 | NFPA 101<br>Corridors - Areas Open to Corridor<br>Corridors - Areas Open to Corridor<br>Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1.<br>18.3.6.1, 19.3.6.1<br>Based on interview and observation; the facility failed to ensure 1 of 3 rehabilitation patient treatment areas were not open to the corridor. LSC 19.3.6.1 states corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5 (see also 19.2.5.4), 19.3.6.1 (7) states paces, other than patient sleeping rooms, treatment rooms, and hazardous areas, shall be permitted to be open to the corridor and unlimited in area provided that all of the following criteria are met: (a) The space and the corridors onto which it opens, where located in the same smoke compartment, are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4. (b) Each space is protected by automatic sprinklers, or the furnishings and furniture, in combination with all other combustibles within the area, are of such minimum quantity and arrangement that a fully developed fire is unlikely to occur. (c) The space does not obstruct access to required exits. This deficient practice could affect all residents that use the therapy gym.<br><br>Findings include:<br><br>Based on observation during a tour of the facility with the Maintenance Director on 01/29/24 at 1:35 | K 0361 | Plan of Correction<br>Ascension Living Sacred Heart Village<br>1/29/2024<br>Preparation and execution of this plan of correction does not constitute Sacred<br>Heart Village admission to or agreement with the facts alleged or conclusions set<br>forth in the Statement of Deficiencies, and such liability is specifically denied. The<br>plan of correction is prepared and executed pursuant to Sacred Heart Village<br>Obligations under federal and state law.<br><br>K TAG -361<br>S/S = E<br>Plan of Correction:<br>1. Corrective action for the 3 residents who had the potential to be affected by<br>the deficient practice.<br>¿ No Residents were being treated or negatively affected. | 02/20/2024 |

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| | p.m., in the St. Clare Neighborhood resident therapy was being conducted in the activity area which was open to the corridor. Based on interview at the time of observation, the Maintenance Director agreed that therapy was being conducted in an area open to the corridor and had therapy staff move to the designated room for therapy.<br><br>This finding was reviewed with the Administrator and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | ¿ The small Hand Cycle that was sitting out on a table was put back into<br>the therapy room immediately, as compliance. EVS director informed<br>the Therapist that no therapy was to be conducted in the St Claire activity area/or therapy equipment to be left out.<br><br>2. How will the facility identify other residents having the potential to be affected<br>by the same deficient practice?<br>¿ Other residents residing in the same facility as of 1/29/2024 were not<br>affected/but could be affected.<br><br>3. The measures the facility will take or systems the facility will alter to ensure<br>that the problem will be corrected and will not recur.<br>¿ Therapy staff members will be re-educated on K 361, so no therapy<br>will be conducted in an area open to the corridor. See attached sheet.<br><br>4. How corrective actions will be monitored to ensure the deficient practice will<br>not recur. Quality Assurance Plans to monitor facility compliance to make<br>sure that corrections are achieved and are permanent. | |

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| | | | ¿ The K Tag 361 has been reviewed by the QAPI team and is aware of the regulation.<br>¿ The EVS director will bring results of the audits monthly to the QAPI meeting for review for 6 months or until 100% compliance is achieved and the QAPI team deems compliance.<br>¿ The Administrator is responsible for compliance<br><br>5. Completion Date:2/20/2024 | |
| K 0363 SS=D Bldg. 01 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the | | | |

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| | closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. | | | |
| | Based on observation and interview, the facility failed to ensure 1 of 1 Nurse Manager office corridor door was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 staff.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 01/29/24 at 12:20 p.m., the corridor to the Nurse Manager office was prop open with a door wedge. Based on interview at the time of observation, the Maintenance Director agreed the corridor door was propped open and stated the self-closer on the door will be removed.<br><br>The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. | K 0363 | Plan of Correction<br>Ascension Living Sacred Heart Villages<br>1/29/2024<br>Preparation and execution of this plan of correction does not constitute Sacred Heart Village 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 Village obligations under federal and state law.<br><br>K TAG -363 S/S=D<br>Plan of Correction: | 02/20/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155512 | A. BUILDING 01<br>B. WING | 01/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| ASCENSION LIVING SACRED HEART VILLAGE | 515 N MAIN ST<br>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 |
|---|---|---|---|---|
| | 3.1-19(b) | | 1. Corrective action for Propped Corridor Door of Nurse Manager Office noted to<br>have been affected.<br>¿ Door had the closure removed before the end of the day to the Nurse<br>Manager office.<br><br>2. How will the facility identify other offices having the potential to be affected<br>by the same deficient practice?<br>¿ Other offices in the facility as of 1/29/2024 could have the potential to<br>be affected.<br>¿ Offices were audited by EVS and none were propped.<br><br>3. The measures the facility will take or systems the facility will alter to ensure<br>that the problem will be corrected and will not recur.<br>¿ Office staff have been re-educated on the citation K 363<br><br>4. Quality Assurance Plans to monitor facility compliance to make sure that<br>corrections are achieved and permanent.<br>¿ Under the direction of the Quality Assurance and Process Improvement<br>(QAPI) Committee, the EVS or designee will audit office doors randomly to ensure no door is propped open. | |

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|---|---|---|---|---|
| | | | ¿ Audits will be submitted and reviewed by the QAPI committee for<br>management of ongoing compliance and will continue until otherwise<br>determined by QAPI committee<br>¿ The administrator is responsible for ensuring ongoing compliance.<br><br>5. Completion Date: DATE: 2/20/2024 | |
| K 0927<br>SS=E<br>Bldg. 01 | NFPA 101<br>Gas Equipment - Transfilling Cylinders<br>Gas Equipment - Transfilling Cylinders<br>Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99).<br>11.5.2.2 (NFPA 99)<br>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking is the immediate area is not permitted. This deficient practice could affect 20 residents in one smoke compartment.<br><br>Findings include: | K 0927 | Plan of Correction<br>Ascension Living Sacred Heart Village<br>1/29/20<br>Preparation and execution of this plan of correction does not constitute Sacred<br>Heart Village admission to or agreement with the facts alleged or conclusions set<br>forth in the Statement of | 02/20/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155512 | A. BUILDING 01<br>B. WING | 01/29/2024 |

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| | Based on observations with the Maintenance Director on 01/29/24 at 12:10 p.m., the oxygen transfilling room contained liquid oxygen tanks. The door to the room was not provided with sign that indicates when transfilling of oxygen is occurring. Based on interview at the time of observation, the Maintenance Director stated there was not a sign that indicates when transfilling of oxygen is occurring.<br><br>The finding was reviewed with the Administrator and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | Deficiencies, and such liability is specifically denied. The plan of correction is prepared and executed pursuant to Sacred Heart village obligations under federal and state law.<br><br>K TAG 927 - S/S=E<br>Plan of Correction:<br>1. Corrective action for residents noted to have been affected by the deficient practice.<br>¿ No residents were affected because the sign of transfilling of oxygen was taking place.<br><br>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>¿ Other residents residing in the facility as of 1/29/2024 and in the same smoke compartment could have the potential to be affected.<br>¿ These residents were not affected by not having the sign that the Transfilling of oxygen was occurring.<br><br>3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.<br>¿ All staff were in-serviced on the | |

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| | | | new sign.<br>the mandatory use of the sign when transfilling oxygen.<br>¿ On or before 2/20/2024 or before their next scheduled working shift.<br>¿ Sign was purchased and received and is now on the door where the<br>transfilling of the oxygen is occurring. See Attached Sheet.<br><br>4. Quality Assurance Plans to monitor facility compliance to make sure that<br>corrections are achieved and permanent.<br>¿ Under the direction of the Quality Assurance and Process Improvement<br>(QAPI) Committee, the EVS Director will bring the notification of the<br>new signage requirement, as stated in K Tag-927, a mandatory requirement of oxygen Transfilling for review.<br>All QAPI/Management staff will be responsible for randomly auditing the use of the sign when oxygen transfilling is occurring. Audits will be<br>submitted and reviewed by the QAPI committee for management of<br>ongoing compliance and will continue until 100% compliance is achieved or as determined by QAPI.<br>¿ The administrator is responsible for ensuring ongoing compliance. | |

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|---|---|---|---|---|
| | | | 5. Completion Date: 2/20/2024 | |