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	01/19/2023

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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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/19/23 Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810 At this Emergency Preparedness survey, Ascension Living Sacred Heart Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 133 certified beds. At the time of the survey, the census was 71. Quality Review completed on 01/23/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification (LSC) and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/19/23 Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810 At this LSC survey, Ascension Living Sacred	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Deffenbaugh	Administrator	02/03/2023

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

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	Heart Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, LSC, Chapter 19, existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detector in the resident rooms. the facility is partly protected by a type II EES 200 kW diesel powered generator. The facility has a capacity of 133 and had a census of 71 at the time of this survey. Quality Review completed on 01/23/23			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to			

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	NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed ensure 2 of 2 cooktops meet the requirements of LSC 19.3.2.5.3. LSC 19.3.2.5.3(9) states a switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director on 01/19/23 at 12:00 p.m. and 12:30 p.m., the St. Paul and St. Anthony kitchenettes contained cooking equipment that was not open to the corridor and did not have access for staff to deactivate the cooktops from power when not in use. Based on interview at the time of observation, the Maintenance Director stated the shut off for the St. Anthony cooktop was in a breaker box in the mechanical room, but staff did not have access to the room or breaker box and the St. Paul cooktop has a gas shutoff but is left on so the pilot light stays on. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0324	K 324 S/S=E What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice; We will get a quote to have the electrical vendor install a disconnect switch on both identified ovens. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Other ovens were inspected. No other residents were affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ·Disconnect switches will be installed on any future ovens used in resident accessible areas to maintain compliance with K324 regulations How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what	02/22/2023

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			quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed. Facilities Director or designee will inspect the ovens to ensure the disconnect switches are present and in proper working condition. Inspection results will be submitted by the Facilities Director or designee to the QAPI Committee monthly for six months to review for trends	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 2	K 0353	K353 S/S=C	02/22/2023

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	carports. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects 35 residents in St. Paul wing. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 01/19/23 at 12:50 p.m., in the suspended ceiling of the St. Paul carport there were vinyl ceiling strips missing and exposed the bottom of the roof about one to two feet above the suspended ceiling. This condition could delay the activation of the sprinklers installed on the suspended ceiling of the carport. Based on interview at the time of the observations, the Maintenance Director stated wind blew the vinyl strips from the carport. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice; .We are obtaining a quote to have the affected carport repaired to regulation standards. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Other carports were inspected by facility maintenance staff. No other residents were affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Carports will be inspected by facility staff to ensure they are in proper working order in compliance with K353. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed. Results of carport inspections will be submitted by the Facilities	

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			Director or designee the QAPI Committee monthly for 6 months to monitor for trends.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure penetrations through 1 of 4 smoke barrier walls in St. Anthony wing were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to	K 0372	K 372 S/S=E What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice; Supplies to achieve compliance have been ordered for the affected smoke barrier. How other residents having the potential to be affected by the same deficient practice will be	02/22/2023

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	accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 30 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 01/19/23 at 12:40 p.m., above the drop ceiling of the smoke wall by room B-2 there was a 4" x 8" cutout in the smoke wall to make room for a water valve. Based on interview at the time of observation, the Maintenance Director agreed there was a water valve that was inside the smoke wall reducing the rating of the smoke wall. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		identified and what corrective action(s) will be taken; Other smoke barriers were inspected. No other residents were affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Facilities Director or designee will inspect smoke barriers to ensure compliance with K 372 regulations. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed. Results of smoke barrier inspections will be submitted by the Facilities Director or designee the QAPI Committee monthly for 6 months to monitor for trends.	
K 0761 SS=E Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of 4 smoke barrier doors in St. Paul wing were routinely inspected and repaired	K 0761	K 761 S/S=E What Corrective Action(s) will be	02/22/2023

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	as part of the facility maintenance program. This deficient practice could affect 23 residents in St. Paul wing. Findings include: Based on observation with the Maintenance Director on 01/19/23 at 12:33 p.m., the smoke door to the St. Paul dining room had 10 screw holes in smoke door. Based on interview at the time of observation, the Maintenance Director agreed the holes in the smoke door needed to be repaired. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		accomplished for those residents found to have been affected by the deficient practice; The affected and identified door was repaired to be in compliance with K 761. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Other smoke barrier doors were inspected by facility maintenance staff. No other residents were affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Smoke barrier doors will be inspected by facility staff to ensure they are in proper working order in compliance with K 761. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed. Results of smoke barrier door inspections will be submitted by	

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			the Facilities Director or designee the QAPI Committee monthly for 6 months to monitor for trends.	