STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155707	A. BUILDING -- B. WING	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLAGE	1350 W MAIN ST BERNE, IN 46711

(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 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/07/25 Facility Number: 000280 Provider Number: 155707 AIM Number: 100274540 At this Emergency Preparedness survey, Swiss Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 128 and had a census of 73 at the time of this survey. Quality Review completed on 01/10/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/07/25 Facility Number: 000280 Provider Number: 155707 AIM Number: 100274540 At this Life Safety Code survey, Swiss Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sierra Saylor	VP of Operations	01/24/2025

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

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	2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (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 detectors in the resident rooms. The facility is partially protected by two type II diesel powered generators. The facility has a capacity of 128 and had a census of 73 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the non-combustible attic spaces above Main Health Care, Edelweiss, and Rehab. Quality Review completed on 01/10/25			
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Based on observation, records review, and interview the facility failed to ensure penetrations in 2 of 2 fire barrier walls that separated health care from other occupancies was maintained to ensure the two-hour fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall,	K 0131	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All residents in these two smoke compartments have the potential to be affected. The areas identified were sealed with an approved filler on January 21, 2025. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what**	01/21/2025

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	155707	A. BUILDING 01 B. WING	01/07/2025

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SWISS VILLAGE	1350 W MAIN ST BERNE, IN 46711

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	floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 01/07/25 between 12:00 p.m. and 12:38 p.m., the following was observed: (a) In the attic of the two-hour separation fire barrier between Assisted Living and Health Care, the pipes going through the wall were sealed with white caulk with an unknown listing. (b) Above the ceiling tiles of the two-hour separation fire barrier between Child Care occupancy and Health Care, there were two unsealed holes through the wall. Based on records review at 12:40 p.m., there was no documentation to show if the white caulk meets ASTM E 814 or ANSI/UL 1479. Based on interviews at the time of observations, the Maintenance Director stated the white caulk listing was unknown and there were unsealed penetrations in the Child Care two-hour separation fire barrier. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**corrective action(s) will be taken.** No other residents were identified. The Director of Facilities Management went through the areas and filled penetrations in the Child Care area with the approved caulk. The white caulk separating the Health Care Area and the Assisted Living area was replaced with approved caulk that meets the ASTME E 814 or ANSI/UL 1479 criteria. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Education was provided to the Director of Facilities and the Vice President of Information Technology regarding the oversight of projects and the need for approved product for sealing holes. Education also provided on oversight of projects including closing any holes created in fire barriers. **4. 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.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the Administrator/designee or the VP of Operations. The Directors of	

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			Facilities and the VP of IT will continue ongoing oversight. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** By February 11, 2025, the systemic changes for this deficiency will be completed.	
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height (#1.) Based on observation and interview, the facility failed to ensure 1 of 2 sets of separation fire barrier walls were constructed with a minimum two-hour fire in accordance with LSC section 19.1. LSC section 19.1.3.3 states sections of health care facilities shall be permitted to be classified as other occupancies, provided that they meet all of the following conditions: (1) They are not intended to provide services simultaneously for four or more inpatients for purposes of housing, treatment, or customary access by inpatients incapable of self-preservation. (2) They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8.	K 0161	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** There were 25 residents in one smoke compartment and 30 in the other that were identified to be affected. The areas identified were corrected on January 22, 2025, by an outside contractor. **2. 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.**	01/22/2025

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	(3) For other than previously approved occupancy separation arrangements, the entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect 25 residents in one smoke compartment. (#2.) Based on observation and interview, the facility failed to maintain the building type of II(111) by ensuring 1 of 2 fire separation barrier assemblies were maintained to ensure the fire resistance of the two-hour barrier and constructed of enclosed noncombustible material in accordance with LSC 19.1. Section 19.1.6.4 states interior nonbearing walls in buildings of Type I or Type II construction shall be constructed of noncombustible or limited-combustible materials, unless otherwise permitted by19.1.6.5 stating interior nonbearing walls required to have a minimum 2-hour fire resistance rating shall be permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided that such walls are not used as shaft enclosures. This deficient practice affects 30 residents in one smoke compartment. Findings include: (#1.) Based on observation with the Maintenance Director on 01/07/25 at 12:30 p.m., in the attic of the two-hour fire separation barrier between health care and assisted living the two-hour fire wall was constructed of cement block with exception of an eight-foot by twelve-foot section that was constructed with wood studs and covered with one sheet of dry wall on each side making this section of the fire wall only having a one hour rating. Based on interview at the time of		No other residents were identified. No other areas were immediately identified. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Director of Facilities was educated that if any other areas are identified, they must be corrected. **4. 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.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the Administrator/designee or the VP of Operations. The Directors of Facilities will continue ongoing monitoring. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.**	

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	observation, the Maintenance Director agreed the drywall section of the wall only had one sheet of drywall on each side and did not have a fire-resistance rating of two hours. (#2.) Based on observation with the Maintenance Director on 01/07/25 at 12:30 p.m., in the attic of the two-hour fire separation barrier between health care and assisted living the two-hour fire wall was constructed of cement block with exception of an eight-foot by twelve-foot section that was constructed with wood studs and covered with one sheet of dry wall on each side. The drywall section of the fire wall had gaps around all edges exposing wood 2x4s and it was unknown if the wood was fire-retardant-treated. Based on interview at the time of observation, the Maintenance Director agreed there were wood 2x4s not fully enclosed and it was unknown if the wood was fire-retardant-treated. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		By February 11, 2025, the systemic changes for this deficiency will be completed.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 2 stairway exits contained exit signs that are displayed in accordance with LSC 7.10 with continuous illumination. This deficient practice could affect 30 residents in the Lavendel hall. Findings include: Based on observation with the Maintenance	K 0293	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** There were 30 residents that were identified by the alleged deficiency. The exit sign was replaced with one under continuous illumination on January	01/08/2025

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	Director on 01/07/25 at 11:14 a.m., the Lavendel stairway exit door was not an obvious exit but was marked as an exit with a small black sign fastened to the door that did not have continuous illumination and could not be seen in the direction of travel. Based on an interview at the time of the observations, the Maintenance Director agreed the stair door was identified as an exit and the sign was not under continuous illumination. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		8, 2025. **2. 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.** No other residents have been affected. A visual walk through was completed on January 24, 2025, to identify any other issues. No other issues have been identified. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Director of Facilities was educated on the need for continuous illumination on required exit signs. **4. 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.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the Administrator/designee or the VP of Operations. The Directors of Facilities will continue ongoing monitoring. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is**	

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			determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. By February 11, 2025, the systemic changes for this deficiency will be completed.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents. Findings include: Based on records review of the sprinkler	K 0353	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All residents have the potential to be affected by alleged deficiency. On January 16, 2025, the spare sprinkler heads and fire department connections were replaced. **2. 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.** The two corrective actions on the vendor report needed were corrected on January 16, 2025. Parts were on order and scheduling was in process for corrective actions needed.	01/16/2025

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	inspection documentation dated 12/04/24 with the Maintenance Director on 01/07/25 at 10:18 a.m., the report stated, the spare sprinkler box contained expired sprinkler heads and there was damage to the fire department connections. There was no documentation to show if the sprinklers were replaced and if the fire department connections were repaired. Based on an interview at the time of record review, the Maintenance Director stated the fire department connections were scheduled to be repaired and are waiting on parts to replace the expired sprinkler heads. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Director of Facilities educated regarding vendor reports and corrective actions. **4. 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.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the Administrator/designee or the VP of Operations. The Directors of Facilities will continue ongoing monitoring. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** By February 11, 2025, the systemic changes for this deficiency will be completed.	

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 9 smoke barrier walls 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 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 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 40 residents in three smoke compartments. Findings include: Based on observation with the Maintenance Director on 01/07/25 between 12:40 p.m. and 1:00 p.m., the following unsealed penetrations were discovered: a) Above the ceiling tiles of the smoke wall by room 374 there were unsealed gaps around pipes and wires. b) Above the ceiling tiles of the smoke wall by room 368 there were unsealed gaps around wires. Based on interview at the time of observation, the	K 0372	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Forty residents were identified in this alleged deficiency in three smoke compartments. The two penetrations of the nine checked were corrected on January 21, 2025. **2. 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.** No other residents were identified. The Director of Facilities Management went through the two halls for rooms 374 and 368 and checked for any other penetrations. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Education was provided to the Director of Facilities and the Vice President of Information Technology regarding the oversight of projects and the need for approved product for sealing holes. Education also provided on oversight of projects including closing any holes created in	02/11/2025

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	Maintenance Director agreed there were unsealed penetrations in the aforementioned smoke walls. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		smoke barriers. **4. 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.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the Administrator/designee or the VP of Operations. The Directors of Facilities will continue ongoing monitoring. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** By February 11, 2025, the systemic changes for this deficiency will be completed.	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on observation, interview, and record review, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans in accordance with 19.7.2.2. LSC 19.7.2.2	K 0711	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	02/10/2025

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	requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Director on 01/07/25 between 10:25 a.m. and 1:00 p.m., throughout the facility there were cross-corridor doors that were either fire barrier doors, smoke barrier doors, and smoke partition/separation doors. Based on records review at 1:10 p.m., there was a map identifying fire barriers, but the map did not indicate which doors were smoke barrier doors or non-barrier separation doors. Based on interview during records review, the Maintenance Director stated some of the cross-corridor doors were not properly identified. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**practice.** All residents and staff have the potential to be affected by this alleged deficiency. Maps of Swiss Village will be updated and replaced regarding smoke barrier doors and fire barrier doors. This will be completed by February 10, 2025. **2. 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.** All residents and staff have the potential to be affected by this alleged deficiency. Education provided to Director of Facilities and VP of Operations regarding the requirements of a fire safety plan. Maps of Swiss Village will be updated and replaced regarding smoke barrier doors and fire barrier doors. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Director of Facilities and VP of Operations educated regarding the requirements for a written health care fire safety plan. **4. 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.**	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLAGE	1350 W MAIN ST BERNE, IN 46711

(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
			This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the Administrator/designee or the VP of Operations. The Directors of Facilities will continue ongoing monitoring. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** By February 11, 2025, the systemic changes for this deficiency will be completed.	