STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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. Survey dates: July 27, 28, 31, August 01 and 02, 2023. Facility number: 000494 Provider number: 155462 AIM number: 100291450 Census Bed Type: SNF/NF: 46 Total: 46 Census Payor Type: Medicare: 3 Medicaid: 34 Other: 9 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 9, 2023.	F 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or an agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request the Department accept this plan as our facility's compliance and request a desk review for credible compliance.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Doug Lynch | HFA | 08/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	Based on observation, interview, and record review, the facility failed to appropriately notify the physician in a timely manor for a resident's change in condition related to a fall for 1 of 14 residents reviewed for notification of change. (Resident 24) Findings include: During an observation and interview on 07/31/23 at 11:05 A.M., Resident 24 was sitting in her room in her wheelchair. She had a brace on her left leg. She indicated she had a fall in the bathroom on the prior Friday morning. CNA (Certified Nurse Aide) 6 was with her in the bathroom. He let her fall to the floor, she didn't have a gait belt on, and they were supposed to put one on her with transfers. She was sitting on the toilet when he stood her up to pull her pants up and she fell. The clinical record for the resident was reviewed on 07/31/23 at 9:30 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 06/01/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, end stage renal failure, anemia, heart failure, hypertension, malnutrition, anxiety, and respiratory failure. The resident required extensive assistance of two or more staff for bed mobility, transfers, dressing, and toilet use. A Fall Event, dated 07/28/23 at 4:14 A.M., indicated the resident had a witnessed fall, with pain on range of motion or movement in the knees. There was no injury noted. A CNA was cleansing the resident while she was standing. She had begun side stepping and threw herself back into the CNA's hands. The resident indicated her knees gave out.	F 0580	**F 580** **It is the standard of this facility to ensure that the physician is notified of changes.** 1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident # 24 had surgery on left distal fracture and returned to the facility. Physician was notified. 2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by this alleged deficient practice. All clinical staff will be in serviced on the facility s Notification of Resident Change of Condition policy on _8/31/23 to include notification of physician DNS/Designee reviewed all resident medical records and to ensure residents MD have been notified for a change of condition. On 08/ /23 an audit of the past 30 days was completed for all residents to ensure proper notification was made for all residents who may have had a change in condition.	09/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	A Progress Note, dated 07/28/23 at 4:22 A.M., indicated the resident was assessed and there were no injuries from the fall. The resident complained of severe pain in the bilateral knees. Tylenol was given. A "Dialysis Center Communication Tool", dated 07/28/23, indicated the resident change in condition information, that the resident complained of a fall that morning at the nursing facility. Her left knee was swollen and painful. Her dialysis run time was cut short due to low blood pressure and pain. A Progress Note, dated 07/28/23 at 12:20 P.M., indicated the resident complained of knee pain once she returned from dialysis. PRN (as needed medication) was provided with a positive effect. The resident would continue to be monitored and updated with changes. A Progress Note, dated 07/28/23 at 1:17 P.M., indicated the physician was notified of complaints. A new order was obtained for an x-ray of the left knee. A Progress Note, dated 07/28/23 at 1:27 P.M., indicated the resident was having discomfort to the left knee. A Progress Note, dated 07/29/23 at 1:47 A.M., indicated the x-ray results were sent to the physician and the facility was awaiting a response. The resident's left knee was assessed with slight swelling and bruising noted. The resident indicated the knee was not hurting at that time but was stiff and unable to move it. A "Radiology Report", dated 07/29/23 at 12:45 A.M., indicated the resident had an acute		3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DNS OR DESIGNEE will review facility activity report during morning meeting and during Gemba rounds with the clinical IDT team. The DNS/Designee will verify if the physician has been notified of any medical status changes. 4.) How the corrective action will be monitored to ensure that the deficient practice will not recur, i.e. what quality assurance program will be put into place? To ensure compliance the DNS/Designee will complete Change of condition QAPI tool weekly x 4weeks, monthly x 6 months and quarterly thereafter. The QAPI committee will determine the need for further review. . If 100% is not achieved an action plan will be developed. Compliance date: 9/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	transcondylar distal femoral fracture. A Progress Note, dated 07/29/23 at 3:58 A.M., indicated and the facility was awaiting a return call from the physician. The resident was resting in bed with her eyes closed. A Progress Note, dated 07/29/23 at 6:47 A.M., indicated a new order was obtained to send the resident to the local hospital for an evaluation and treatment. A Progress Note, dated 07/29/23 at 3:00 P.M., indicated the resident returned from the local hospital with a 3-panel knee splint to the left knee/leg. The resident was to follow up with her physician for further recommendations. The hospital orthopedics denied surgery for the resident due to too many health factors. The Hospital Emergency Room Report, dated 07/29/23, included, but was not limited to, a diagnostic report for a history of trauma that indicated the resident had a femoral fracture that demonstrated impaction. Bone fragments were splayed proximally 15 mm (millimeters) on the medial and lateral side. An Orthopedist was consulted, and the resident was a high risk for surgery due to age and significant comorbidity. A transfer was recommended to a higher level of care. The resident declined surgical intervention at the time. During a return phone call interview on 08/01/23 at 2:07 P.M., LPN 7 indicated the morning of the fall she went into the bathroom and the residents' legs were straight out in front of her and she complained of her knees bothering her. Her and CNA 6 lifted the resident off the floor and put her in her chair. CNA 6 was usually able to get her on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	and off the toilet without using a gait belt by the resident grabbing the bar. She gave the resident Tylenol and applied cream to her knees. She was able to move both of her legs. The resident always had knee pain and her knees gave out frequently. She sent a text message to the physician and didn't get a response, so she went ahead and sent her to dialysis. She would normally send a text message to the physician and not call. On 08/02/23 at 9:00 A.M., the Administrator provided a written statement by LPN 7 the statement indicated the following: - Statement from LPN 7 indicate, she was called to the bathroom and was notified that the resident had fallen. She went to the bathroom and the resident was sitting on the floor in front of the toilet with her legs stretched out with complaints of her knees hurting. CNA 6 had used a gait belt and took it off due to the resident complaining about it. She assessed the resident's legs and she complained of her knees hurting but was able to complete range of motion to bilateral legs. She was lifted to the chair, and she finished getting ready for dialysis. She was given Tylenol with her morning medications and cream was applied to both knees. There was no bruising or redness noted to her knees. She left for dialysis soon after the fall. The physician was notified. The clinical record lacked physician notification or acknowledgement of the notification until 07/28/23 at 1:17 P.M. (9 hours and 3 minutes after the resident fell with complaints of pain) During an interview on 08/02/23 at 9:13 A.M., LPN 4 indicated when a resident had a fall, he would notify the physician by a phone call. They were always available anytime to call.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	The current facility policy titled, "Resident Change in Condition", with a revised date of 11/2018, was provided by the Clinical Support Nurse on 08/01/23 at 2:38 P.M. The policy indicated, "...It is the policy of the facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place...2. Acute Medical Change...any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician. If unable to contact the attending physician or alternate physician in a timely manner, notify the Medical Director for medical interventions...Non-Urgent Medical Change...all symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly. Non-urgent changes are minor change in physical and mental behavior, abnormal laboratory, and x-ray results that are non-life threatening...The nurse in charge is responsible for notification of physician and family/responsible party prior to end of assigned shift when a significant change in the resident's condition is noted. If unable to reach the physician or family/responsible party, all calls to physicians or exchanges and family/responsible party requesting callbacks will be documented in the medical record..." 3.1-5(a)(2)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	Based on record review and interview, the facility failed to accurately complete MDS (Minimum Data Set) assessments related to special treatments, falls, and nutritional status for 3 of 14 residents reviewed for accuracy of assessments. (Residents 9, 30, and 37). Findings include: 1. A Quarterly MDS assessment, dated 07/03/23, indicated Resident 9 was cognitively intact. The diagnoses included, but were not limited to, spinal bifida and diabetes. The resident required limited staff assistance for most ADLs (Activities of Daily Living). "Section O" of the assessment indicated the resident participated in occupation therapy during the assessment review period and did not participate in AROM (Active Range of Motion) and walking restorative nursing services. During an interview on 08/02/23 at 10:09 A.M., the Therapy Manager indicated the resident participated in restorative nursing services. His walking program started on 04/05/23, and the AROM program had been in place since December of 2022. During an interview on 08/02/23 at 11:35 A.M., the MDS Coordinator indicated she would pull a computer report to determine if a resident participated in restorative nursing services during the assessment review period. The MDS Coordinator provided the resident's restorative nursing report for 06/27/23 through 07/03/23 on 08/02/23 at 11:36 A.M. The report indicated the resident participated in AROM services on six days of the review period and participated in the walking program on one day of the review period.	F 0641	F 641 It is the standard of this facility to ensure MDS (Minimum Data Set) assessments accurately reflect the resident's status. 1. What corrective action be accomplished for those residents found to have been affected by the deficient practice? MDS's were modified and re-submitted to CMS on 8/2/23. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this alleged deficient practice. An audit of all MDS assessments was completed on all residents on 8/7/23by MDS nurse consultant to ensure all assessments accurately reflect the resident's status. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur? Starting on 8/7, the RAI consultant will be auditing and closing all MDS's. After being checked all assessments will have corrections done if needed. Once completed they will be closed and submitted to CMS. The MDS Coordinator was in-serviced on 8/7/23 by the Nurse Consultant regarding correct completion of all sections of the	09/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	2. A Quarterly MDS assessment, dated 06/13/23, indicated Resident 30 was severely cognitively impaired. The diagnoses included, but were not limited to, dementia and heart failure. "Section J" of the assessment indicated the resident had not experienced any falls since the last assessment (a Quarterly MDS assessment that was completed on 03/13/23). A "Fall Event Report" indicated the resident experienced an unwitnessed fall with some bruising noted on 04/10/23 at 6:35 P.M. A "Fall Event Report" indicated the resident experienced an unwitnessed fall with no injury noted on 04/11/23 at 12:10 P.M. During an interview on 08/02/23 at 11:28 A.M., the MDS Coordinator indicated the two falls the resident experienced in April should have been reflected on the 06/13/23 MDS assessment. 3. A Quarterly MDS assessment, dated 07/06/23, indicated Resident 37 was rarely understood. The diagnoses included, but were not limited to, hypertension, aphasia, and depression. "Section K" indicated the resident was on a mechanically altered diet and feeding tube was not marked during the seven-day review period. The June and July 2023 EMAR/ETAR (Electronic Medication Administration/Electronic Treatment Administration Record) indicated the resident had received, but were not limited to, the following enteral feeding from 06/30/23 through 07/06/23: - Enteral Feeding: Bolus Feeding, 120 ml (milliliters) every 3 hours while awake, - Enteral Feeding: Check placement of tube and check residual and hold feeding if residual was		MDS. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? To ensure compliance the RAI Consultant/or designee will implement a MDS audit tool weekly x 4 weeks, monthly x 6 months and quarterly thereafter. DNS and/or designees audit of the MDS will be brought to the CQI meeting weekly by the DNS and/or designee for 6 months for review by the IDT. Results of these audits will also be brought to QAPI meeting monthly for further review and recommendations for 6 months. At the end of that time, if 100% compliance is reached, the committee may decide to stop the documented audits and the RAI Consultant/or designee check of the MDS. Date of Compliance: 9/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	greater than 100 ml, three times a day, and - Enteral Feeding: Flush tube with 240 ml, water, every 6 hours. A "Nutritional Status" Care Plan, with a start date of 12/22/22, indicated the resident required enteral nutrition to meet nutrition needs. During an interview on 08/02/23 at 11:44 A.M., the MDS Coordinator indicated the Registered Dietician, or the Dietary Manager would complete Section K of the MDS assessment. The dietician would make sure that section was completed, and she guessed she would be the one to review them, then an RN would sign the final completed assessment. They would obtain the information for the MDS assessment from the resident's diet orders. The resident received bolus feedings through a feeding tube during the seven-day look back period and should have been marked on the MDS assessment dated 07/06/23. During an interview on 08/02/23 at 11:28 A.M., the MDS Coordinator indicated she would complete her assessments based off the RAI (Resident Assessment Instrument) manual. 3.1-31(c)(3) 3.1-31(c)(5) 3.1-31(c)(11)			
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to complete neurological assessments after a fall for 1 of 6 residents reviewed for accidents. (Resident 30) Findings include: During an interview on 07/28/23 at 10:49 A.M., Resident 30 indicated she had a few falls in last few months. A Quarterly MDS (Minimum Data Set) assessment, dated 06/26/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, vascular dementia, heart failure, and hypertension. The resident had not experienced any falls since the last assessment. A "Fall Event Report" indicated the resident experienced an unwitnessed fall with some bruising noted on 04/10/23 at 6:35 P.M. The resident was first observed laying on her right side with her right arm up under the bed head board with her right side sitting on the trash can. Neurochecks (neurological checks) were initiated and the MD was notified. A "Fall Event Report" indicated the resident experienced an unwitnessed fall with no injury noted on 04/11/23 at 12:10 P.M. The resident was first observed on her knees between the bed and recliner. Neurochecks were not initiated, a note indicated the resident was "already on neurochecks". Neurological Assessments were provided by the	F 0684	**F684** **It is the standard of this facility to ensure that residents receive treatment and care in accordance with professional standards of practice.** 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Neurological checks will be performed after any unwitnessed fall or if a resident his/her head. 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 have the potential to be affected. All clinical staff will be in-serviced on the facility's Neurological checks policies by DNS/designee. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DON or her designee upon learning of a fall will check that proper policy and procedure for neurochecks has been initiated and followed through with. 4) How the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?	09/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	Clinical Support Nurse on 08/02/23 at 10:17 A.M. Neurochecks began on 04/10/23 at 6:00 P.M., when the resident had her first fall and were completed appropriately for that fall. The resident's record lacked documentation of neurochecks that should have started on 04/11/23 at 12:10 P.M., when the resident experienced a second fall. During an interview on 08/02/23 at 10:32 A.M., LPN (Licensed Practical Nurse) 4 indicated neurochecks should be conducted after an unwitnessed fall or if a resident fell and hit their head. Residents were to be assessed every 15 minutes x one hour, every 30 minutes x 2 hours, every hour x 4 hours, and every 8 hours x 72 hours. If a resident was on neurochecks and had another fall that required neurochecks, the neurochecks would start over from the beginning, every 15 minutes x one hour and so on. The current "Fall Management Policy" with a revised date of 8/2022, was provided by the Regional Clinical Support on 08/02/23 at 11:20 A.M. The policy indicated, "...A neurological assessment will be initiated on all unwitnessed falls..." 3.1-37(a)		To ensure compliance the DNS/Designee will complete a Neurological check audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Neurological check CQI audit tool audit tool will be reviewed monthly by the CQI Committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If 100 % compliance is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. 5) Compliance dates: 9/2/23	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure a resident that was incontinent of bowel received appropriate treatment and services to maintain a healthy bowel elimination pattern for 1 of 2 residents reviewed for bowel and/or bladder function. (Resident 35) Findings include: During an interview on 07/28/23 at 10:54 A.M., Resident 35 indicated he had recently been hospitalized for a bowel blockage and had some	F 0690	**F 690** **It is the standard of this facility to ensure that residents receive the appropriate perineal/catheter care related to infection control guidelines to prevent urinary infections.** 1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	09/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	trouble with his bowels before. The resident's clinical record was reviewed on 08/01/23 at 1:58 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 05/16/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, emphysema, and schizophrenia. The resident experienced a limitation in their functional range of motion on both sides of their upper and lower extremities and required extensive staff assistance for ADLs (Activities of Daily Living). The resident was frequently incontinent of urine and always incontinent of bowel. The resident's complete Care Plan was provided by the Clinical Support Nurse on 08/02/23 at 9:38 A.M., and included a care plan, with a start date of 04/18/22, related to the resident's risk for constipation due to decreased motility. the interventions included, but were not limited to the following approaches with a start date of 04/18/22: - Document abnormal findings and notify MD, - Administer medications as ordered, - Notify MD if no BM after 3rd day, and - Abdominal assessment if no BM x 4 days. Document and notify MD of abnormal findings. A facility progress note, dated 07/19/23 at 12:55 P.M., indicated an x-ray was performed and indicated an ileus (the inability of the bowels to contract normally and move waste out of the body) type pattern was favored and an obstruction was not excluded. The resident was sent to a local hospital to be evaluated.		All clinical staff will be in-serviced on Bowel Elimination by the DNS/Designee on 08/31/23. 2.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by this alleged deficient practice. All clinical staff will be in-serviced on the facilities Bowel Elimination policies on 08/31/23. An audit was conducted on 8/24/23 to ensure that no other residents were affected this alleged deficient practice. 3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DNS/ADNS or designee will monitor Bowel Elimination during the Clinical Morning Meeting and during Gemba rounds daily. 4.) How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	A facility progress note, dated 07/20/23 at 1:22 A.M., indicated the resident was admitted to the hospital with a small bowel obstruction, urinary tract infection, and low potassium. The resident returned to the facility on 07/21/23. The resident's vitals report for June and July 2023 was provided by RN 5 on 08/02/23 at 2:05 P.M. and indicated the following: - On 06/06/23 at 11:03 P.M., the resident had a large bowel movement. - On 06/07/23 at 10:52 A.M., the resident had no bowel movement. - On 06/08/23 at 11:19 A.M., the resident had no bowel movement. - On 06/09/23 at 12:38 A.M., 12:35 P.M., and 8:22 P.M., the resident had no bowel movement. - On 06/10/23 at 12:46 P.M., the resident had no bowel movement. - On 06/11/23 at 1:28 A.M., 7:34 A.M., and 9:50 P.M. the resident had no bowel movement. - On 06/12/23 at 1:33 P.M. and 3:00 P.M., the resident had no bowel movement. - On 06/28/23 at 12:21 P.M., the resident had a large bowel movement. - On 06/28/23 at 7:25 P.M., the resident had no bowel movement. - On 06/30/23 at 4:49 A.M., 3:52 P.M., and 7:26 P.M., the resident had no bowel movement. - On 07/01/23 at 2:43 P.M. and 7:45 P.M., the resident had no bowel movement. - On 07/02/23 at 9:19 A.M. and 7:38 P.M., the resident had no bowel movement. - On 07/03/23 at 2:59 P.M., the resident had no bowel movement. - On 07/04/23 at 4:11 A.M., the resident had a large bowel movement.		To ensure compliance the DNS/ADNS or designee will complete a Bowel Elimination audit tool weekly x 4 weeks , monthly x 6months and quarterly thereafter. The CQI Committee will determine the need for further review. If 100% is not achieved an action plan will be developed. Compliance Date: 09/02/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	During an interview on 08/01/23 at 2:11 P.M., RN 5 indicated that nurse aides documented bowel movements daily in the computer. The computer generated a report that would trigger residents that hadn't had a bowel movement to be reviewed. They discussed this report daily in the morning meeting. If a resident hadn't had a bowel movement after 3 days, they would work on trying to get the resident to go. They would give PRN (as needed) medications if they were ordered, and they would notify the MD. They would document what they did in a progress note or they would create an "Event" in the computer. The resident's progress notes and "Event" documentation from 06/01/23 through 07/04/23 were reviewed and lacked documentation related to the resident's bowel movements or lack thereof. The resident's June and July 2023 EMAR (Electronic Medication Administration Record) was reviewed and included but was not limited to the following physician's orders: - An open ended physician's order, with a start date of 04/20/22, to administer a glycerin rectal suppository once a day as needed for constipation., and - An open ended physician's order, with a start date of 10/03/22, to administer polyethylene glycol 3350 powder; 17 grams once a day as needed as indicated for constipation. The June and July 2023 EMARs lacked documentation that the PRN medications were administered. The current facility policy, titled "Bowel Elimination", dated 01/2015, was provided by the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	Clinical Support Nurse on 08/02/23 at 9:38 A.M. The policy indicated, "...A resident bowel report will be completed by the assigned charge nurse of the resident(s) who have not had a bowel movement for 3 consecutive days...Any resident not having a bowel movement for 3 consecutive days, will be given a laxative or stool softener, as prescribed by the physician, at the end of the 3rd day...If by the 4th afternoon, the resident (s) has not had results, the nurse will do an abdominal assessment, chart the results of the assessment, and notify the physician for further order..." 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	(5) of this section. Based on observation, interview, and record review, the facility failed to follow physicians orders related to medication hold parameters for 2 of 6 residents reviewed for unnecessary medications. (Residents 4 and 38) Findings include: 1. During an observation and interview on 07/27/23 at 1:36 P.M., Resident 4 was sitting on her bed, with her call light within reach. She indicated she had no concerns. The clinical record for the resident was reviewed on 07/31/23 at 2:59 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 05/20/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, atrial fibrillation, hypertension, cancer, anxiety, and insomnia. An open-ended physician's order, with a start date of 06/01/23, indicated the staff were to administer Midodrine (a hypotensive medication), 2.5 mg (milligrams), twice a day. The medication was to be held if the systolic (top number/heart at work) blood pressure was greater than 120. The June and July 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident had received the Midodrine medication when her systolic blood pressure was greater than 120 on the following dates and times: - On 06/13/23 at 8:00 A.M. the resident's blood pressure was 126/70 and at 4:00 P.M. the blood pressure was 126/70. - On 06/18/23 at 4:00 P.M., the resident's blood	F 0757	F 757 It is the standard of this facility to ensure a resident is free from unnecessary medications related to medication hold parameters. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? DNS and or designee notified MD, POA, and residents of medication errors and times administered. No resident was found to have a negative outcome that required medical treatment outside of facility. Med error report given and reviewed with all nurses who administered medications despite hold orders. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with medication hold parameters have the potential to be affected. DNS and /or designee reviewed all EMARS for hold parameters on 8/1/23. Med error report given and reviewed with all nurses who administered medications despite hold orders. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur? DNS will audit all medications with parameters daily starting 8/1/23 at	09/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	pressure was 128/70. - On 06/19/23 at 4:00 P.M., the resident's blood pressure was 144/81. - On 06/26/23 at 4:00 P.M., the resident's blood pressure was 132/68. - On 06/30/23 at 8:00 A.M., the resident's blood pressure was 127/62. - On 07/02/23 at 4:00 P.M., the resident's blood pressure was 127/56. - On 07/04/23 at 4:00 P.M., the resident's blood pressure was 137/87. - On 07/05/23 at 8:00 A.M., the resident's blood pressure was 135/75. - On 07/07/23 at 8:00 A.M., the resident's blood pressure was 132/64. - On 07/08/23 at 8:00 A.M., the resident's blood pressure was 133/73. - On 07/09/23 at 4:00 P.M., the resident's blood pressure was 133/70. - On 07/11/23 at 8:00 A.M., the resident's blood pressure was 140/81. - On 07/14/23 at 8:00 A.M., the resident's blood pressure was 123/60 and at 4:00 P.M. the blood pressure was 126/72. - On 07/15/23 at 4:00 P.M., the resident's blood pressure was 131/54. - On 07/20/23 at 8:00 A.M., the resident's blood pressure was 129/66 and at 4:00 P.M. the blood pressure was 123/64. During an interview on 08/01/23 at 11:23 A.M., RN 3 indicated if a resident had a medication that required hold parameters the vitals would be documented in the EMAR. If the vitals were outside the parameters to give the medication, then it should be held and documented in the EMAR as to why it wasn't given. Staff should notify the physician if needed. 2. During an observation and interview on 07/27/23 at 11:14 A.M., Resident 38 was sitting in		the Morning Clinical meeting to ensure compliance. DNS will ensure that the EMAR vital sign alert range is set to the hold parameter number for any medications with hold parameters. All nurses and QMA's will be inserviced on medications with hold parameters on 8/31/23. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? To ensure compliance the DNS and/or designee will complete a medication general audit tool for 4 weeks, monthly times 6 months and quarterly thereafter. -The CQI committee will determine the need for further review. If a 100% threshold is not achieved, an action plan will be developed. 5. Completion date: 9/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	his room in his wheelchair. He indicated he was feeling well today. The clinical record for the resident was reviewed on 08/01/23 at 3:10 P.M. A Quarterly MDS assessment, dated 06/27/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, stroke, dementia, and atrial fibrillation. An open-ended physician's order, with a start date of 03/21/23, indicated the staff were to administer digoxin (a heart rhythm medication), 125 mcg (micrograms), once a day, in the morning. The medication was to be held if the heart rate was less than 60 beats per minute. The April and May 2023 EMAR/ETAR indicated the resident had received the digoxin medication when his heart rate was below 60 on the following dates: - On 04/05/23, the resident's heart rate was 58 beats per minute. - On 05/12/23, the resident's heart rate was 58 beats per minute. - On 05/14/23, the resident's heart rate was 54 beats per minute. During an interview on 08/02/23 at 3:13 P.M., the Clinical Support Nurse indicated the facility did not have a specific policy related to following medication hold parameters. 3.1-48(a)(3)			
F 0761 SS=E 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	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 and interview, the facility failed to store medications appropriately related to having multiple unsecured loose tablets in the medication carts for 3 of 3 medication carts reviewed. (Medication Carts on the 200 Hall, 300 Hall, and 100 Hall) Findings include: 1. The 200 Hall Medication Cart was observed on 07/31/23 at 10:42 A.M., with LPN (Licensed Practical Nurse) 2 and contained the following loose pills laying in the bottom of the drawers: - two small white oval tablets,	F 0761	F 761 It is the standard of this facility to store medications appropriately related to having multiple unsecured loose tablet in the medication carts. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No resident had ill effects related to this alleged deficient practice. Medications were immediately removed or discarded. 2. How will the facility identify	09/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	- one medium white oval tablet, - two small tan round tablets, - one small white round tablet, - two small pink round tablets, and - two clear round tablets. During an interview on 07/31/23 at 10:44 A.M., LPN 2 indicated the medications that were dropped in the drawers needed to be accounted for, destroyed, and the pharmacy should be notified that the 30 day count would be off. 2. The 300 Hall Medication Cart was observed on 07/31/23 at 10:45 A.M., with RN 3 and contained the following loose pills laying in the bottom of the drawers: - two small white oval tablets, - one small white round tablet, - two small pink round tablets, and - one medium yellow round tablet. 3. The 100 Hall Medication Cart was observed on 07/31/23 at 11:11 A.M., with LPN 4 and contained the following loose pills laying in the bottom of the drawers: - one small round white tablet, - 1/2 of a yellow oval tablet, - one small pink round tablet, and - one small tan round tablet. The current medication storage policy, dated January 2022, was provided by the Administrator on 08/01/23 at 11:26 A.M. The policy indicated, "...2. Facility should ensure that all medications and biologicals are stored in an orderly manner...9. Facility should ensure that the medications and biologicals for each resident are stored in the containers in which they were originally		other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. No residents were affected by this alleged deficient practice. All medication carts were inspected to ensure medications were stored appropriately by the DNS/Designee 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur? DNS and/or designee will inservice all nurses and QMAs on medication storage 8/31/23. DNS/Designee will complete a cart audit to ensure medications are stored properly. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? To ensure compliance the DNS and/or designee will complete a medication storage general audit tool for four weeks, and monthly for six month and then quarterly thereafter. The CQI Committee will determine the need for further review. If a 100% threshold is not achieved, an action plan will be developed. 5. Completion date: 9/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	received..." 3.1-25j) 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(4) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(k)(7)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on observation, interview, and record review, the facility failed to obtain laboratory results and communicate with the physician in a timely manner for 1 of 16 residents reviewed for laboratory services. (Resident 4) Findings included: During an observation and interview on 07/27/23 at 1:36 P.M., Resident 4 was sitting on her bed, with her call light within reach. There were no observed bruising or signs of bleeding. She indicated she was doing well. A Quarterly MDS (Minimum Data Set) assessment, dated 05/20/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, atrial fibrillation,	F 0770	F 770 It is the standard of this facility to ensure a resident is free from unnecessary medications related to medication hold parameters. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? DNS/designee reviews the Coumadin orders to ensure the MD has been notified timely of lab results. No resident were found to have a negative outcome that required medical treatment outside of facility.	09/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	hypertension, cancer, anxiety, and insomnia. An open-ended physician's order, with a start date of 11/22/21, indicated the resident was to have a PT/INR (Prothrombin Time/ International Normalized Ratio) [a blood clotting test], once a day, every Monday. A Progress Note, dated 05/11/23 at 9:46 A.M., indicated the resident was status post fall with multiple bruising and hematomas. The resident had no complaints of pain or discomfort. The resident continued on antibiotics related to a UTI (Urinary Tract Infection). There was no abnormal bleeding noted related to the coumdin therapy. A call was placed to lab (laboratory) for STAT (immediately), PT/INR. The May 2023 EMAR/ETAR (Electronic Medication Administration/Electronic Treatment Administration Record) indicated the resident had received 3.5 of warfarin on 05/11/23 in the P.M. (evening). The resident's PT/INR lab results were provided by the Regional Clinical Support on 08/02/23 at 2:37 P.M. The lab results lacked a lab drawn on 05/11/23. The resident's STAT PT/INR was not drawn until 5/12/23. A Progress Note, dated 05/12/23 at 1:01 P.M., indicated the PT/INR results were sent to the MD. The levels were elevated at this time. The Warfarin (Coumadin) was put on hold until 05/16/23. A Progress Note, dated 05/15/23 at 5:56 P.M., indicated the resident's PT/INR level was obtained per lab. The results were sent to the MD with a new order to start Warfarin 3 mg (milligrams) daily		2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who receive Coumadin have the potential to be affected. DNS and /or designee reviewed all residents on Coumadin have been reviewed for timely MD notification of lab results. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur? DNS/designee will review the PT/INR results and MD notification daily at the clinical morning meeting. All nurses and QMA's will be in-serviced on notifying MD in timely manner of PT/INR results on 8/31/23. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? To ensure compliance the DNS and/or designee will complete a Coumadin lab results audit weekly for 4 weeks, monthly x 6 months and quarterly thereafter, by the IDT committee. The CQI committee will determine the need for further review. If a 100% threshold is not achieved, an action plan will be developed. 5. Completion date: 9/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	and check PT/INR on 05/16/23. A Progress Note, dated 05/16/23 at 10:28 A.M., indicated the resident had a pending STAT PT/INR at that time. A Progress Note, dated 05/16/23 at 1:22 P.M., indicated the lab was there to draw the STAT PT/INR. The May 2023 EMAR/ETAR indicated the resident had received 3 mg of Warfarin on 05/16/23. A Progress Note, dated 05/17/23 at 10:04 A.M., indicated the MD was in to see the resident. The PT/INR was reviewed and a new order was obtained to discontinue Warfarin 3 mg and start Warfarin 4 mg every day. A Progress Note, dated 06/19/23 at 3:13 P.M., indicated a new order was received for a PT/INR to be obtained on Thursday (06/22/23). The June 2023 EMAR/ETAR indicated the resident had received 4 mg of warfarin on 06/22/23. A Progress Note, dated 06/23/23 at 11:55 A.M., indicated the PT/INR was sent to the MD. No changes at that time. During an interview on 08/02/23 at 1:45 P.M., LPN (Licensed Practical Nurse)4 indicated when a resident had a PT/INR lab order they would obtain the lab, get the results, and send them to the physician. The nurses should communicate with the physician the same day as the PT/INR lab level was drawn before the next does of medication was given. If the physician didn't			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	respond before the dose was due he would continue to get a hold of them before the medication was administered. Any resident on coumadin had a tracking log. It was in the binder on the nurses cart. When the form was full it would be turned into medical records. At 2:24 P.M., LPN 4 indicated when a resident had an order to obtain a PT/INR the lab would come to the facility and obtain it. The lab came every Monday, Wednesday, and Friday. If it was a STAT lab they came 24/7 (everyday/anytime). Any STAT lab should be obtained within 4 hours after calling the lab. If the lab wasn't going to be able to get to the facility and draw it in the 4 hours, then he would follow-up with the physician and document it in a progress note. When the PT/INR was drawn they were faxed to the facility the same day or they could view them online. During an interview on 08/02/23 at 2:37 P.M., the Regional Clinical Support indicated the resident didn't have a coumadin tracking log. The ones on the cart were internal documents and they didn't keep them as a part of the clinical record. The facility would discard them appropriately. The current facility policy titled, "Labs and Diagnostics" dated 11/2017, was provided by the Regional Clinical Support on 08/02/23 at 2:58 P.M. The policy indicated, "...to provide or obtain laboratory and diagnostic services to meet the need of its residents. The facility is responsible for the quality and timeliness of the service...Reports or results that are filed in the medical record must be signed and dated for physician notification..." The current facility policy titled, "Coumadin/Warfarin Monitoring Policy and Tracking Log" with a revised date of 11/2018, was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	provided by the Regional Clinical Support on 08/02/23 at 2:58 P.M. The policy indicated, "...Residents who require Coumadin Therapy are receiving adequate monitoring...The resident who receives Coumadin/Warfarin will have a Coumadin/Warfarin INR tracking log implemented...Prior to administering the Coumadin/Warfarin dose the licensed nurse should verify the most current PT/INR..." 3.1-49(a)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to maintain a facility pantry snack refrigerator for all residents related to unlabeled	F 0812	**F812** It is the practice of this provider to maintain kitchen sanitation in	09/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
	items and outdated items for 1 of 1 snack refrigerator reviewed. Findings include: The facility pantry snack refrigerator was observed with LPN (Licensed Practical Nurse) 4 on 08/02/23 at 11:15 A.M. The snack refrigerator contained the following items: - A nearly full container of prune juice labeled with opened on date of 07/22/23, use by date of 07/28/23, - A nearly empty gallon of iced tea with a use by date of 07/23/23, and - An individual sized box of pizza labeled with a resident's name. The box was not dated to indicate when it was brought into the facility. During an interview on 08/03/23 at 11:17 A.M., LPN 4 indicated he was not sure if the gallon of tea belonged to a particular resident or if it was provided by the facility. Food items brought in by families should be labeled with the resident's name and the date it was brought in. The current facility policy, titled "Food Brought in by Family and Visitors" was provided by the Administrator during the entrance conference on 07/27/23. The policy indicated, "...If food must be stored, it will be labeled with the resident's name, the date the item was brought in and the date by which it should be consumed or discarded...Staff will monitor for food in need of disposal..." 3.1-21(i)(3)		accordance with state and federal regulations. Facility to ensure storage of food/food delivery products stored by FiFO per policy and expired food items will be discarded timely. **What corrective action will be accomplished for those residents found to been affected by the deficient practice?** Prune juice, container of iced tea, pizza box, were discarded. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected. All other nourishment pantries were checked to ensure all items were labeled properly and outdated items were discarded by CM/designee. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** CM/Designee to provide in-service to culinary and nursing staff on food service storage and labeling and food brought from outside the facility. Food pantry to be checked daily by CM/designee to ensure food is properly stored, labeled ad if necessary discarded. **How the corrective action(s) will** **be monitored to ensure the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

(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
			deficient practice will not recur? CM to complete AM checklist weekly x 4 weeks and monthly x 6 to ensure proper storage of food in pantries. If 95% is not achieved an action plan will be implemented. Results will be reviewed by the QAPI committee. Compliance date: 9/10/23	