STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155462	A. BUILDING -- B. WING	08/23/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/23/23 Facility Number: 000494 Provider Number: 155462 AIM Number: 100291450 At this Emergency Preparedness survey, Swiss Villa Nursing and Rehabilitation was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 72 certified beds. At the time of the survey, the census was 48. Quality Review completed on 08/28/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** We respectfully request paper compliance/desk review of all citations as none are deemed immediate jeopardy. Please contact Kyle Stout, HFA @ 812-427-2803 with any questions. Thank you for your time.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kyle Stout	Executive Director	09/08/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155462	A. BUILDING -- B. WING	08/23/2023

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

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	§494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.			

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	155462	A. BUILDING -- B. WING	08/23/2023

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SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

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	. Based on record review and interview, the facility failed to maintain 1 of 2 emergency preparedness plans that were reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the nurse's station version of "Emergency Preparedness Program" documentation dated 11/08/17 with the Administrator, the Administrator in Training (AIT) and the Maintenance Supervisor during record review from 10:25 a.m. to 1:05 p.m. on 08/23/23, documentation for the nurse's station version of emergency preparedness program was not reviewed within the most recent twelve monnth period. The aforementioned plan was dated as being reviewed on 11/08/17 which was not within the most recent twelve month period. The Administrator maintains a complete version of "Emergency Preparedness Program" documentation which was dated 08/24/22 which was within the most recent twelve month period. Based on interview at the time of record review, the Administrator, the AIT and the Maintenance Supervisor agreed the nurse's station version of emergency preparedness program documentation was not documented as being reviewed within the most recent twelve month period. These findings were reviewed with the Administrator, the AIT and the Maintenance Supervisor during the exit conference.	E 0004	E004 It is the practice of this facility to develop an EP Plan, Review and Update Annually. **The corrective action taken for those residents found to be affected by the deficient practice include:** EPP binders have been reviewed in their entirety and acknowledged and signed by Executive Director on 9/7/23. **Other residents that have the potential to be affected have been identified by:** All residents, staff and visitors have the potential to be affected but none were identified. EPP binders have been reviewed in their entirety and acknowledged and signed by Executive Director on 9/7/23. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Executive Director/Maint Director has been in-serviced on the company policy and procedure and will maintain the emergency preparedness program by reviewing annually, after an event, or as needed. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** Executive Director shall review binders annually, after	09/09/2023

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			an event, or as needed and present to QAPI meeting quarterly. **Date of Completion: 9/9/23**	
E 0006 SS=C Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan			

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	155462	A. BUILDING -- B. WING	08/23/2023

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SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

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	that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk			

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	assessment. Based on record review and interview, the facility failed to maintain 1 of 2 emergency preparedness plans that were (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach which was reviewed within the most recent twelve month period and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on review of the nurse's station version of "Emergency Preparedness Program" documentation dated 11/08/17 with the Administrator, the Administrator in Training (AIT) and the Maintenance Supervisor during record review from 10:25 a.m. to 1:05 p.m. on 08/23/23, the nurse's station version of the documented facility-based and community-based risk assessment was not reviewed within the most recent twelve month period. Based on interview at the time of record review, the Administrator stated 11/08/17 was the date of the most recent review of the nurse's station version of the emergency preparedness program documentation. These findings were reviewed with the Administrator, the AIT and the Maintenance Supervisor during the exit conference.	E 0006	It is the practice of this facility to have an emergency plan based on All Hazards Risk Assessment, including strategies for addressing emergency events identified by the risk assessment. **The corrective action taken for those residents found to be affected by the deficient practice include:** A facility and community-based risk assessment has been completed and includes 2 strategies for addressing events identified by the risk assessment. **Other residents that have the potential to be affected have been identified by:** All residents, staff and visitors have the potential to be affected but none were identified. A facility and community-based risk assessment has been completed and includes 2 strategies for addressing events identified by the risk assessment. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Executive Director/Maintenance Director have been in-serviced on All Hazards Risk Assessment including strategies for addressing emergency events identified by the risk assessment. **The corrective action taken to monitor performance to assure**	09/09/2023

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			compliance through quality assurance is: Executive Director/Designee will report findings to QAPI and will monitor risk assessment yearly and as needed. **Date of Completion: 9/9/23**	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this			

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	section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			

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	Based on record review and interview, the facility failed to review and update its emergency preparedness policies and procedures to include policies and procedures for emerging infectious diseases (EID). The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all occupants. Findings include: Based on review of the nurse's station version of "Emergency Preparedness Program" documentation dated 11/08/17 with the Administrator, the Administrator in Training (AIT) and the Maintenance Supervisor during record review from 10:25 a.m. to 1:05 p.m. on 08/23/23, the nurse's station version of the emergency preparedness policies and procedures was not reviewed within the most recent twelve month period. Based on interview at the time of record review, the Administrator stated 11/08/17 was the date of the most recent review of the nurse's station version of the emergency preparedness program documentation . These findings were reviewed with the Administrator, the AIT and the Maintenance Supervisor during the exit conference.	E 0013	It is the practice of this facility to have an emergency plan to include preparedness policies and procedure for emerging infectious diseases. **The corrective action taken for those residents found to be affected by the deficient practice include:** Emerging Infectious Disease Policy has been added to Emergency Preparedness Plan. Policy has been reviewed and will update annually and as needed. **Other residents that have the potential to be affected have been identified by:** All residents, staff, and visitors have the potential to be affected but none were identified. Emerging Infectious Disease Policy has been added to Emergency Preparedness Plan. Policy has been reviewed and will update annually and as needed. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Executive Director/Maintenance Director have been in-serviced regarding emerging infectious diseases to be included in the Emergency Preparedness Plan. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The Emergency Operations Plan has been updated	09/09/2023

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			to include Emerging Infectious Diseases. Executive Director shall review binders annually, after an event, or as needed and present to QAPI meeting quarterly. **Date of Completion: 9/9/23**	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws which was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the nurse's station version of "Emergency Preparedness Program" documentation dated 11/08/17 with the	E 0029	It is the practice of this facility to have an updated Emergency Preparedness Communication Plan that complies with Federal, State, and local laws which is reviewed and updated at least annually. **The corrective action taken for those residents found to be affected by the deficient practice include:** EPP binders with the communication plan have been	09/09/2023

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	Administrator, the Administrator in Training (AIT) and the Maintenance Supervisor during record review from 10:25 a.m. to 1:05 p.m. on 08/23/23, the nurse's station version of the emergency preparedness communication plan was not reviewed by the facility within the most recent twelve month period. Based on interview at the time of record review, the Administrator stated 11/08/17 was the date of the most recent review of the nurse's station version of emergency preparedness program documentation. These findings were reviewed with the Administrator, the AIT and the Maintenance Supervisor during the exit conference.		reviewed/updated in their entirety and acknowledged and signed by Executive Director on 9/7/23. **Other residents that have the potential to be affected have been identified by:** All residents, staff, and visitors have the potential to be affected but none were identified. EPP binders with the communication plan have been reviewed/updated in their entirety and acknowledged and signed by Executive Director on 9/7/23. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Executive Director/Maint. Director has been educated on the company policy and procedure and will maintain the emergency preparedness program by reviewing annually, after an event, or as needed. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** Executive Director shall review binders annually, after an event, or as needed. Executive Director shall review binders annually, after an event, or as needed and present to QAPI meeting quarterly. **Date of Completion: 9/9/23**	

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SWISS VILLA NURSING AND REHABILITATION	1023 W MAIN ST VEVAY, IN 47043

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E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the			

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	155462	A. BUILDING -- B. WING	08/23/2023

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

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	communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.	E 0036	It is the practice of this facility to develop and maintain an emergency preparedness training and testing program that is reviewed and updated at least annually. **The corrective action taken for**	09/09/2023

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	Findings include: Based on review of the nurse's station version of "Emergency Preparedness Program" documentation dated 11/08/17 with the Administrator, the Administrator in Training (AIT) and the Maintenance Supervisor during record review from 10:25 a.m. to 1:05 p.m. on 08/23/23, the facility's emergency preparedness training and testing program documentation was not reviewed within the most recent twelve month period. Based on interview at the time of record review, the Administrator stated 11/08/17 was the date of the most recent review of the nurse's station version of emergency preparedness program documentation. These findings were reviewed with the Administrator, the AIT and the Maintenance Supervisor during the exit conference.		**those residents found to be affected by the deficient practice include:** EPP binders have been reviewed and updated in their entirety and acknowledged and signed by Executive Director on 9/7/23. **Other residents that have the potential to be affected have been identified by:** All residents, staff, and visitors have the potential to be affected but none were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Executive Director/Maint. Director has been educated on the company policy and procedure and will maintain the emergency preparedness program by reviewing annually, after an event, or as needed. EPP binders have been reviewed and updated in their entirety and acknowledged and signed by Executive Director on 9/7/23. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** Executive Director shall review binders annually, after an event, or as needed. **Date of Completion: 9/9/23**	
K 0000 Bldg. 01				

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	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: 08/23/23 Facility Number: 000494 Provider Number: 155462 AIM Number: 100291450 At this Life Safety Code survey, Swiss Villa Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 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 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor and has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 72 and had a census of 48 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility storage were sprinklered. Quality Review completed on 08/28/23	K 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** We respectfully request paper compliance/desk review of all citations as none are deemed immediate jeopardy. Please contact Kyle Stout, HFA @ 812-427-2803 with any questions. Thank you for your time.	
K 0200 SS=D Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress			

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	requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 Based on observation and interview, the facility failed to ensure 1 of 1 Activity Director's Office egress doors was free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. This deficient practice could affect over 1 staff in the Activity Director's Office in the Main Dining Room. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:05 p.m. to 2:55 p.m. on 08/23/23, the egress door for the Activity Director's Office in the Main Dining Room had one lock on the door which required a key to open the door from each side of the door. Based on interview at the time of the observations, the Maintenance Supervisor agreed the door lock required a key from the egress side of the door. These findings were reviewed with the Administrator, the Administrator in Training and the Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0200	It is the practice of this facility to develop and maintain an Emergency Preparedness Plan that ensures egress doors are free of all obstructions or impediments to full instant use in the case of fire or other emergency. **The corrective action taken for those residents found to be affected by the deficient practice include:** The egress door for the Activity Director's Office in the Main Dining Room has been replaced and is fully operational. **Other residents that have the potential to be affected have been identified by:** This alleged deficient practice could affect over 1 staff in the Activity Director's Office in the Main Dining Room. All other doors were inspected by maintenance director to ensure the doors were free from impediments and to provide instant use. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Egress doors will be monitored and checked in TELS with Preventative Maintenance weekly. Maintenance Director	09/09/2023

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			in-serviced on ensuring egress doors are free from of all obstructions or impediments. Executive Director to ensure Preventative Maintenance is completed and documented in TELS weekly. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** Maintenance Director will review document in Tels and present to the QAPI meeting monthly. If 100% is not achieved an action plan will be implemented. **Date of Completion: 9/9/23**	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of smoke detectors in all resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's	K 0300	It is the practice of this facility to ensure documentation for the preventative maintenance of smoke detectors in all resident rooms are completed. **The corrective action taken for those residents found to be affected by the deficient practice include:** All smoke detectors have been cleaned.	09/09/2023

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	published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Supervisor during the initial walk through of the facility from 10:10 a.m. to 10:25 a.m. on 08/23/23, battery operated smoke detectors are installed in each resident sleeping room. Based on interview at the time of the observations, the Maintenance Supervisor stated there about three different models of battery operated smoke detectors installed in the facility's resident sleeping rooms. Based on review of Direct Supply TELS Logbook Documentation "Detectors: Test battery operated smoke detectors" for the most recent twelve month period with the Maintenance Supervisor during record review from 10:25 a.m. to 1:05 p.m. on 08/23/23, resident sleeping room smoke detector cleaning documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated he was not aware if smoke detector cleaning documentation for the most recent twelve month period was available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 1:05 p.m. to 2:55 p.m. on 08/23/23, manufacturer's documentation affixed to the Kidde Model i9010 smoke detector on the ceiling in Room 100 stated to clean the detector annually. Manufacturer's documentation affixed to the First Alert Model 0827 smoke detector on the ceiling in Room 503 stated to clean		**Other residents that have the potential to be affected have been identified by:** All residents, staff, and visitors have the potential to be affected but none were identified. All smoke detectors have been cleaned by the Maintenance Director **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Documentation for the preventive maintenance of smoke detectors in all residents rooms have been documented in TELS under Test Battery Operated Smoke Detectors and will continue to be completed monthly. Maintenance Director in-serviced on ensuring documentation for the preventative maintenance of smoke detectors in all residents rooms are completed monthly in TELS. Executive Director to ensure Preventative Maintenance is completed and documented in TELS monthly. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** Maintenance Director will present Tels documentation regarding cleaning of smoke detectors to QAPI meeting. If 100% is not achieved, an action plan will be developed. **Date of Completion: 9/9/23**	

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	the unit monthly. Manufacturer's documentation affixed to the Universal Security Instruments Model MI30505 smoke detector on the ceiling in Room 505 stated to clean the detector monthly. Based on interview at the time of the observations, the Maintenance Supervisor agreed resident sleeping room smoke detector cleaning documentation for the most recent twelve month period was not available for review. These findings were reviewed with the Administrator, the Administrator in Training and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain automatic sprinkler systems in	K 0353	It is the practice of the facility to maintain automatic sprinkler	12/31/2023

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	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, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 04/11/23 with the Maintenance Supervisor during record review from 10:25 a.m. to 1:05 p.m. on 08/23/23, deficiencies were noted during the annual sprinkler system inspection for the facility. The "Deficiency Summary" section of the 04/11/23 sprinkler system annual inspection report stated "Room 407 is missing escutcheon" and the following sprinkler locations were not free of corrosion or physical damage or were not free of foreign materials including paint: a. (3) heads in kitchen which are very difficult to access. b. (1) head behind dryer is loaded. c. (1) head in the bathroom to Room 103 is loaded. d. (1) head in Room 105 is painted.		systems in accordance with NFPA 25. All sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25. **The corrective action taken for those residents found to be affected by the deficient practice include:** Integrated Electronics to make necessary repairs on the following: Room 407 missing escutcheon, 3 heads in kitchen to be replaced, sprinkler head in 300 Hall Spa needs relocated away from heater, 2 heads in 200 Hall Spa are corroded, head in Room being replaced. Corrected: Head behind dryer is loaded, head in bathroom to Room 103 is loaded, head in Room 102 is loaded, sprinkler escutcheon in 100 Hall Laundry is painted **Other residents that have the potential to be affected have been identified by:** All residents, staff, and visitors have the potential to be affected but none were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Maintenance Director in-serviced on maintaining automatic sprinkler s Life Safety code waiver request submitted. IEI ordered parts for above deficiencies and will complete the necessary repairs once parts are	

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	e. (1) head in Room 102 is loaded. f. (1) sprinkler escutcheon in 100 Hall Laundry is painted. g. (1) sprinkler head in 300 Hall Spa needs relocated away from electric heater. h. (2) heads in 200 Hall Spa are both corroded. Based on interview at the time of record review, the Maintenance Supervisor stated corrections have not been made on or after 04/11/23 for the deficiencies noted during the annual inspection. The Maintenance Supervisor provided a letter from the sprinkler system inspection contractor dated 08/14/23 stating "During the annual sprinkler inspection, several deficiencies were noted by our technician. A quote was sent to the customer, and we received verbal approval on August 1, 2023. Parts have been ordered and once they are delivered, we will schedule technicians to return and make all necessary repairs". These findings were reviewed with the Administrator, the Administrator in Training and the Maintenance Supervisor during the exit conference. 3.1-19(b)		delivered. Maintenance Director will ensure that automatic sprinkler systems are in accordance with NFPA 25 and documented in TELS per regulation. systems in accordance with NFPA 25. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** Life Safety QA for Sprinkler system will be completed monthly for 6 months by the Maintenance Director/Designee. The results of these audits will be reviewed by the ED during QAPI meeting. If 100% is not achieved an action plan will be implemented. **Date of Completion: Waiver 12/31/23**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors			

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	to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 3 of 45 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include:	K 0363	It is the practice of the facility to ensure that all corridor doors to be free of impediments to closing and latching into the door frame and would resist the passage of smoke. **The corrective action taken for those residents found to be affected by the deficient**	09/09/2023

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	Based on observations with the Maintenance Supervisor during a tour of the facility from 1:05 p.m. to 2:55 p.m. on 08/23/23, the corridor door to resident sleeping Room 108, Room 202 and Room 309 were each propped in the fully open position with a trash can placed on the floor up against the door. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned three corridor doors each had an impediment to closing and latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Administrator, the Administrator in Training and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**practice include:** Room 108, Room 202, Room 309 – All impediments removed and doors are clear of obstruction. **Other residents that have the potential to be affected have been identified by:** This alleged deficient practice could affect over 20 residents, staff and visitors. All other rooms were checked for impediments or obstructions from preventing doors to close. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** All staff in-serviced on keeping corridor doors free of impediments or obstruction. Maintenance Director to ensure weekly checks are performed and all corridor rooms are free of impediments. Executive Director to ensure Preventative Maintenance is completed and documented in TELS weekly. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** Life Safety QA for door closures will be completed monthly for 6 months by the Maintenance Director/Designee. The results of these audits will be reviewed by the ED during QAPI meeting. If 100% is not achieved an action plan will be implemented.	

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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
			Date of Completion: 9/9/23	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs			

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	cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 indoor oxygen storage areas was in accordance with NFPA 99, Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 3000 cubic feet shall comply with 5.1.3.3.2 and 5.1.3.3.3. Section 5.1.3.3.2 states, if indoors, storage locations of positive-pressure gases shall be constructed and use interior finishes of noncombustible or limited combustible materials such that all walls, floor, ceilings, and doors are of minimum 1-hour fire resistant rating. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the 300 Hall oxygen storage and transfilling room. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:05 p.m. to 2:55 p.m. on 08/23/23, one electrical outlet box was installed in the north wall of the 300 Hall oxygen storage and transfilling room approximately eight inches above the floor and was without its cover plate. The opening in the wall for the outlet box exposed the structural elements of the wall behind the drywall installed in the room and did not ensure all walls of the room were of minimum 1-hour fire resistant rating. Four liquid oxygen containers and six 'E' type oxygen cylinders were stored in the room. Based on interview at the time of the observations, the	K 0923	It is the practice of this facility to ensure that the indoor oxygen storage area is in accordance with NFPA 99. **The corrective action taken for those residents found to be affected by the deficient practice include:** Both electrical outlet boxes located in the oxygen storage room have been replaced. **Other residents that have the potential to be affected have been identified by:** This alleged deficient practice could affect over 10 residents, staff and visitors in the vicinity of the 300 Hall oxygen storage and transfilling room. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur:** Maintenance Director has been in-serviced oxygen storage interior finishes. The maintenance director will inspect the oxygen storage area to ensure all interior finishes of oxygen storage are in accordance to code during his monthly PM rounds. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The Executive	09/09/2023

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	Maintenance Supervisor agreed the oxygen storage and transfilling room was not maintained with a minimum 1-hour fire resistant rating. These findings were reviewed with the Administrator, the Administrator in Training and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlet boxes in the 300 Hall oxygen storage and transfilling room was protected. NFPA 99 Health Care Facilities Code, 2012 Edition, Section 5.1.3.3.2 (5) and 5.1.3.3.2 (10) both require locations for central supply systems and the storage of positive-pressure gases to protect electrical devices from physical damage. A.5.1.3.3.2 (5) states electrical devices should be physically protected, such as by use of a protective barrier around the electrical devices, or by location of the electrical device such that it will avoid causing physical damage to the cylinders or containers. For example, the device could be located at or above 5 feet above the finished floor or other locations that will not allow the possibility of the cylinders or containers to come into contact with the electrical device as required by this section. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the 300 Hall oxygen storage and transfilling room. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:05 p.m. to 2:55 p.m. on 08/23/23, one electrical outlet box was installed in the north wall in the 300 Hall		Director will ensure preventative maintenance checks are performed by the maintenance director monthly and documented in TELS. Life Safety QA for Oxygen Room will be completed monthly for 6 months by the Maintenance Director/Designee. The results of these audits will be reviewed by the ED during QAPI meeting. If 100% is not achieved an action plan will be implemented. **Date of Completion: 9/9/23**	

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	oxygen storage and transfilling room approximately eight inches above the floor and was without its cover plate. The cover plate was broken into two pieces and was lying on the floor underneath the outlet box. Based on interview at the time of the observations, the Maintenance Supervisor agreed the electrical outlet box was not protected by a protective barrier and was installed less than 5 feet above the floor. These findings were reviewed with the Administrator, the Administrator in Training and the Maintenance Supervisor during the exit conference. 3.1-19(b)			