			PRINTED: 10/28/202
EPARTMENT OF HEALTH AND HU	FORM APPROVED		
ENTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00	COMPLETED

OF CORRECTION	IDENTIFICATION NUMBER 155462	A. BUILDING 00 B. WING		00	COMPLETED 10/02/2024	
NAME OF PROVIDER OR SUPPLIER SWISS VILLA NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 1023 W MAIN ST VEVAY, IN 47043			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
This visit was for a Recertification and State Licensure Survey. Survey dates: September 26, 27, 30, October 1 and 2, 2024		F 0000		this facility's written allegation of compliance for the deficiencies cited. This submission of this	of	
Facility number: 00 Provider number: 1.	55462			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		
Census Payor Type: Medicare: 4 Medicaid: 37 Other: 4 Total: 45				review for credible compliance		
accordance with 410	0 IAC 16.2-3.1.					
Notify of Changes	(Injury/Decline/Room, etc.)					
failed to notify a ph urinalysis for 1 of 1 notification of chan Findings include:	ysician related to obtaining a 3 residents reviewed for ge. (Resident 21) for Resident 21 was reviewed	F 05	80	be implemented for those residents found to have been affected by deficient practice Resident 21's UA results were received on 6/18/24 indicating UTI. The MD was made aware How other residents having	? no	10/22/2024
	This visit was for a Licensure Survey. Survey dates: Septe 2, 2024. Facility number: 00 Provider number: 1: AIM number: 10029 Census Bed Type: SNF/NF: 45 Total: 45 Census Payor Type: Medicare: 4 Medicaid: 37 Other: 4 Total: 45 These deficiencies r accordance with 410 Quality review comusity of Changes Based on record revialed to notify a phurinalysis for 1 of 1 notification of changes Findings include: The clinical record:	PROVIDER OR SUPPLIER //ILLA NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for a Recertification and State Licensure Survey. Survey dates: September 26, 27, 30, October 1 and 2, 2024. Facility number: 000494 Provider number: 155462 AIM number: 100291450 Census Bed Type: SNF/NF: 45 Total: 45 Census Payor Type: Medicare: 4 Medicaid: 37 Other: 4 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 7, 2024. 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to notify a physician related to obtaining a urinalysis for 1 of 13 residents reviewed for notification of change. (Resident 21)	PROVIDER OR SUPPLIER //ILLA NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for a Recertification and State Licensure Survey. Survey dates: September 26, 27, 30, October 1 and 2, 2024. Facility number: 000494 Provider number: 155462 AIM number: 100291450 Census Bed Type: SNF/NF: 45 Total: 45 Census Payor Type: Medicare: 4 Medicaid: 37 Other: 4 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. 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This submission of this plan of correction is not an admission of or an agreement the deficiencies cited. This submission of this plan of correction is not an admission of or an agreement the deficiencies cited. This submission of this plan of correction is not an admission of or an agreement the deficiencies cited. This submission of	PROVIDER OR SUPPLIER //LLA NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIE (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for a Recertification and State Licensure Survey. Survey dates: September 26, 27, 30, October 1 and 2, 2024. Facility number: 100494 Provider number: 150462 AIM number: 100291450 Census Bed Type: SNF/NF: 45 Total: 45 Census Payor Type: Medicare: 4 Medicare:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Kyle Stout **Executive Director** 10/18/2024

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

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155462	B. WING		10/02/2024		
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			/ MAIN ST		
SWISS V	/ILLA NILIPSING AN	ND REHABILITATION			, IN 47043		
300133 V	TILLA NUNSING AI	ND REHABILITATION		VEVAI	, 111 47 043		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		et) assessment, dated 09/05/24,			same deficient practice will	be	
		ent was severely cognitively			identified and what corrective	re e	
	_	lent's diagnoses included, but			action will be taken?		
		, dementia, hypertension, and			All residents have the potentia	al to	
	-	sident was occasionally			be affected by this alleged		
	incontinent of bow	el and bladder.			deficient practice.		
					An audit of all residents for an	ıy	
	-	Report, titled "Hot Charting-			change of condition and MD		
	· ·	Background, Assessment, and			notification with a response ha	as	
	· ·	Physician Communication			been completed by		
		/24, indicated the resident had			DNS/Designee.		
	_	ng urine with burning on			What measures will be put in	nto	
urination. The nurse requested, from the				place or what systemic			
physician, for a UA (Urinalysis) culture and				changes will be made to			
	sensitivity.				ensure that the deficient		
					practice does not recur?		
	A Physician's Note, dated 06/18/24, indicated the				An audit tool for all residents t		
	staff were to obtain a sample for a urinalysis that				monitor for Change of Conditi	on	
	day and the physician would treat the results				and MD notification with a		
	appropriately.				response will be checked by		
		1. 1. 106/10/24 11 11			DNS/Designee.		
	the urinalysis resu	lts, dated 06/19/24, indicated			All licensed nurses will be		
	the resident did not	nave an infection.			educated on Change of Cond		
		1 1 1 6 4 26 2			and notifying the MD no later	tnan	
		lacked any further notification er the initial notification on			10-22-24 by DNS/Designee.		
					DNS/designee will review the		
		18/24, related to the resident's			facility activity report for any	. 41	
	concerns or obtaini	ng the UA.			change of condition and notify		
	During on interview	w on 10/02/24 at 9:22 A.M., LPN			MD. They will continue to mor	IIIOI	
	_	Nurse) 3 indicated if a nurse			daily to ensure the MD has		
		From an order to obtain a UA, she			responded until they get a response from him/her.		
		SBAR. If she sent the SBAR in			How the corrective action wi		
		ould have a response back from			be monitored to ensure the	""	
		nch time. If she didn't get a			deficient practice will not		
		ne would call the physician's			recur, i.e. what quality?		
		nt it in a progress note.			DNS/designee will be response	sihle	
	office and documen	in it in a progress note.			for Change of Condition QAP		
	During an interview	w on 10/02/24 at 10:48 A.M., the			_	1 1001	
		Nursing) indicated if the staff			to be completed weekly X 4, monthly X 6 months, and qua	rtorly	
		vursing į murcaicu II tile Stati	1		i monuniy a dinonuis, and qua	ileliv I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155462 B. WING 10/02/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1023 W MAIN ST SWISS VILLA NURSING AND REHABILITATION **VEVAY. IN 47043** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE asked the physician for a UA, they would send an for one year, with results reported SBAR to the physician or call the physician's to assurance programs will be put office. They would obtain the order and transcribe in place for prevention? The QAPI it into the health record. The staff should get a committee overseen by the ED. If response back from an SBAR the same day they a threshold of 95% is not send it. The staff should have documented the achieved, an action plan will be physician's response to the SBAR on 06/12/24. developed. By what date will systemic changes be completed? The current facility policy, titled "Resident Change of Condition", with a revision date of 10/22/24 11/2018, was provided by the DON on 10/02/24 at 11:24 A.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..." 3.1-5(a)(3)F 0776 483.50(b)(1)(i)(ii) SS=D Radiology/Other Diagnostic Services Bldg. 00 Based on record review and interview, the facility F 0776 What corrective action will be 10/22/2024 failed to obtain diagnostic services in a timely accomplished for those manner for 1 of 13 residents reviewed for residents found to have been radiology and diagnostic services. (Resident 6) affected by the deficient practice? Findings include: Staff educated on obtaining diagnostic services in a timely The clinical record for Resident 6 was reviewed on manner. Resident 6 Doppler was 10/01/24 at 9:53 A.M. A Quarterly MDS (Minimum completed on 11-13-2023. Data Set) assessment, dated 08/21/24, indicated How other residents have the the resident was rarely or never understood. The potential to be affected by the resident's diagnoses included, but were not same deficient practice will be limited to, dementia and hypertension. identified and what corrective actions will be taken? A Progress Note, dated 11/07/23 at 11:33 A.M., All residents have the potential to

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indicated the resident's LLE (Left Lower

Extremity), leg, was inflamed, red, and warm, and

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deficient practice.

be affected by this alleged

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/02/2024 155462 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1023 W MAIN ST SWISS VILLA NURSING AND REHABILITATION **VEVAY. IN 47043** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE An audit for diagnostic/lab A Progress Note, dated 11/08/23 at 2:40 A.M., services was conducted on indicated the resident's LLE continued to be 10/18/24 by the DNS/Designee to reddened and the redness was moving up to his ensure that no other residents inner thigh. were affected by this alleged deficient practice. There were no A Facility Event Report, titled "Hot Chartingidentified concerns. -SBAR (Situation, Background, Assessment, and What measures will be put into Recommendation) Physician Communication place or what systemic Tool", dated 11/07/23, at 11:17 A.M., indicated the changes will be made to resident's LLE was inflamed, red, and warm. The ensure that the deficient recommendation was to obtain a venous doppler. practice does not recur? The physician was notified. The report lacked any An audit tool for all residents to information related to the diagnostic services monitor for Diagnostic test will be availability time frame. reviewed and monitored to ensure the test has been competed in a A Radiology Order, dated 11/07/23, was provided timely manner. by the DON on 10/02/24 at 12:05 P.M. The order The DNS/ADNS or designee will indicated the resident was to have a doppler of monitor Labs/diagnostics during the LLE for a possible DVT (Deep Vein the Clinical Morning Meeting and Thrombosis), blood clot. during Gemba rounds daily to ensure lab/diagnostics are The diagnostic services doppler report was completed timely as ordered. provided by the DON on 10/02/24 at 11:54 A.M., All licensed nurses will be and indicated the procedure was completed on educated on timely diagnostic 11/13/23. The facility received the results on tests by DNS/Designee. 11/14/23. The results of the doppler indicated the How the corrective actions will resident had a DVT. be monitored to ensure the deficient practice will not During an interview on 10/02/24 at 11:41 A.M., recur, what quality assurance LPN (Licensed Practical Nurse) 3 indicated if they program will be put into place? received an order for a doppler, they had to put To ensure compliance the the order in, then the doppler technician would DNS/ADNS or designee will call and let them know when they could do the complete a Labs/Diagnostics audit procedure. If it needed to be done right away, tool weekly x 4 weeks, monthly x they sent residents to the local hospital. The staff 6months and quarterly thereafter. let the MD know what was going on with the The CQI Committee will determine resident's symptoms and the doctor made the the need for further review. If 100% determination as to if the time frame from the is not achieved an action plan will

technician was okay. If a resident had symptoms,

be developed.

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155462	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/02/2024	
	ROVIDER OR SUPPLIEF	ID REHABILITATION		1023 W	ADDRESS, CITY, STATE, ZIP COD MAIN ST , IN 47043		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	the staff would let to symptoms were and the SBAR. The doc the SBAR form. If time frame from the documented on the During an interview Administrator on 10 indicated when a dot the order into the labere in the facility to used the same labed was an emergent sit residents out to the the MD ordered the The results were away was a weekend, soon hours. The current facility Change of Condition 11/2018, was provided 11:24 A.M. The poof the facility that a condition will be condition with a revise provided by the DO. The policy indicate to a dignified existence will be communication with the symptoms are sufficiently as the condition will be condition with the current facility Rights with a revise provided by the DO. The policy indicate to a dignified existence will be communication with the condition will be condition with the current facility Rights.	he MD know what the document the symptoms on tor responds to the SBAR on staff had notified the MD of the edoppler technician, it would be SBAR form as well. We with the DON and the DON and the DON 2/24 at 11:49 A.M., they oppler was ordered they put be company, and they were within 24 to 48 hours. They had ompany for a long time. If it truation, they could send local hospital but, normally, and to be completed in-house. The ailable in 24 hours unless it metimes it would be 24 to 48 policy, titled "Resident on" with a revision date of ded by the DON on 10/02/24 at licy indicated, "It is the policy ll changes in resident ommunicated to the physician			CROSS-REFERENCED TO THE APPROPRIA	πE	
	3.1-49(g)						

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	TE OF DEFICIENCIES		(V2) MIII TIDI T ~	ONGTRUCTION		D NO. 0930-039		
		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY			
		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
		155462	B. WING		10/02/	2024		
NAME OF PROVIDER OR SUPPLIER SWISS VILLA NURSING AND REHABILITATION			1023 V	STREET ADDRESS, CITY, STATE, ZIP COD 1023 W MAIN ST VEVAY, IN 47043				
(VA) ID	CLIMMADY	CTATEMENT OF DEFICIENCIE	ID.	T		(7/5)		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)		
PREFIX	-	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION		
TAG F 0790		R LSC IDENTIFYING INFORMATION	TAG			DATE		
SS=D	483.55(a)(1)-(5)	ov Dontal Cares in CNEs						
	Routine/Emergen	cy Dental Srvcs in SNFs						
Bldg. 00	Događan aksamisti	on, interview, and record	E 0700	VA/In a to a mine a time a cation in (a) visible to		10/22/2024		
			F 0790	What corrective action(s) will be accomplished for those residents found to have been affected by the		10/23/2024		
	I	failed to acknowledge a						
		es and notify the dentist of						
		mely manner for 1 of 1 resident		deficient practice?				
	reviewed for dental	i. (Resident 36)		0	_			
	Eindines in dede			Correspondence with in-house	9			
	Findings include:			dental provider has been				
	D . 1 .	. 1:4		/replacement set of dentures				
	_	ion and interview on 09/27/24						
	· ·	ident 36 was sitting in his		made. Resident and/or family				
		urse's station. He was		notified.				
		teeth) and indicated his						
		ing. He had told the						
		at it and was unsure how long						
	they had been miss	ing.						
	Duning on intermien	v on 10/01/24 at 1:28 P.M., RN 4			_			
	_	inaware the resident had		How other residents having th				
		maware the resident had		potential to be affected by the				
	dentures.			same deficient practice will be	1			
	Daning on internal	10/01/24 -4 1-20 D.M. J.DNI		identified and what corrective action(s) will be taken:				
		w on 10/01/24 at 1:29 P.M., LPN Nurse) 3 indicated the resident						
	did not have dentur			All registered began the materials	.1.4			
	did not have dentui	es.		All residents have the potentia				
	During on interview	v on 10/01/24 at 1:30 P.M., CNA		be affected by the alleged defi	cient			
	_	ide) 5 indicated she was		practice.¿				
	1	dent ever having dentures.						
	unaware of the resi	dent ever having dentures.						
	During an interview	v on 10/01/24 at 1:59 P.M., the						
	_	e Director) indicated when the						
	1	facility to give a resident their		Audit completed by SSD of all				
		would be made aware of it. She		residents in facility to identify				
		resident having dentures, but		immediate dental needs.				
		rk said he did. He was last seen		miniediate defital fieeds.				
		8/11/24 when they came and						
	cleaned his denture	•						
l .	I Transa ins acinture	··	1	1		1		

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was rescheduled.

resident's dentures were going to be delivered but

the resident was at the hospital and the delivery

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dental provider to ensure

appropriate care plans are in place

when a resident receives dentures,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		a. Building <u>00</u>		COMPLETED		
		155462	B. WING		10/02/2024	
	1	I REHABILITATION STATEMENT OF DEFICIENCIE	1023 W	ADDRESS, CITY, STATE, ZIP COD / MAIN ST /, IN 47043	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		
				CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
TAG	A Dental Note, date resident was doing were delivered a fewere cleaned that do the resident's invertesident had dentured. The Complete Care 07/25/24, lacked a control of the current facility Services/Missing Double 9/17, was provided A.M. The policy inneeded dental servicemergency dental sthese services and results dental services as not the current facility Rights" with a revision provided by the DC The policy indicate right to dignity and	policy titled, "Dental lentures" with a revised date of by the DON on 10/02/24 at 9:35 dicated, "The facility obtains ces, including routine and ervices; assists in providing makes prompt referrals for	TAG	and it is placed on personal inventory sheet. By what date the systemic changes will be completed: 10/23/2024	DATE	

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