PRINTED: 08/28/2023

DEPARTMENT	FORM APPROVED OMB NO. 0938-039					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A			(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION X	(X3) DATE SURVEY COMPLETED 08/16/2022	
	PROVIDER OR SUPPLIE		1023 V	ADDRESS, CITY, STATE, ZIP COD V MAIN ST		
500155 V	ILLA NURSING AI	ID REHABILITATION	VEVA	/, IN 47043		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000 Bldg		paredness Survey was adiana Department of Health in CFR 483.73.	E 0000			
	Survey Date: 08/16	/22				
	Facility Number: ( Provider Number: AIM Number: 100	155462				
	Villa Nursing and I compliance with En Requirements for M	Preparedness survey, Swiss Rehabilitation was found in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR				
	The facility has 72 the survey, the cens	certified beds. At the time of sus was 52.				
	Quality Review con	mpleted on 08/17/22				
K 0000						
Bldg. 01						
Š	Licensure Survey v	Recertification and State was conducted by the Indiana Ith in accordance with 42 CFR	K 0000	This Plan of Correction constitut this facility's written allegation of compliance for the deficiencies cited. This submission of this plat of correction is not an admission of or an agreement with the	an	

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

At this Life Safety Code survey, Swiss Villa

Facility Number: 000494

Provider Number: 155462

AIM Number: 100291450

TITLE

compliance.

deficiencies or conclusions

contained in the Department's

inspection report. We respectfully

request the Department accept this plan as our facility's

(X6) DATE

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.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155462	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/16/2022
	PROVIDER OR SUPPLIEI	R ND REHABILITATION	1023 V	ADDRESS, CITY, STATE, ZIP COD V MAIN ST 7, IN 47043	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	Y FULL PREFIX PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	compliance with Remodicare/Medicare/Medicare/Medicare/In Medicare/In Medicare/	idents have customary access All areas providing facility		We also request the Departm consider an IDR request of cit K521. A HVAC Damper Inspet was completed on 3/20/2020. dampers are identified on the inspection report.  Lastly, we respectfully request paper compliance/desk reviewall citations as none are deem immediate jeopardy. Please contact Megan Lengerich, HF 812-427-2803 with any questi Thank you for your time.	t v of hed
K 0211 SS=F Bldg. 01	discharges, exit lo in accordance wit of egress is contin all obstructions to emergency, unles through 18/19.2.1 18.2.1, 19.2.1, 7.	- General ays, corridors, exit ocations, and accesses are h Chapter 7, and the means nuously maintained free of full use in case of ss modified by 18/19.2.2 1.	K 0211	What corrective action(s) wi	II 09/01/2022
	interview; the faciliof egress free from egress. LSC 19.2.3 required width shall	obstructions in 4 of 9 means of 3.4(4) states, projections into the l be permitted for wheeled at that all of the following	22.02.1	be accomplished for those residents found to have bee affected by the deficient practice?  No residents, staff	n

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	NG <u>01</u>	COMPLETED	
		155462	B. WING		08/16/2022	
NAME OF I	PROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP COL	)	-
NAME OF I	PROVIDER OR SUPPLIED	X	102	23 W MAIN ST		
SWISS \	ILLA NURSING AN	ND REHABILITATION	VE	VAY, IN 47043		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	CTION (X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFI	PROVIDER'S PLAN OF CORRECTY  (EACH CORRECTIVE ACTION SHOUNDS)  CROSS-REFERENCED TO THE APP	IND BE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAC	DEFICIENCY)	DATE	
	conditions are met:			visitors were affected by	the	
	(a) The wheeled eq	uipment does not reduce the		alleged deficient		
		corridor width to less than 60		<u> </u>	cation	
	in. (1525 mm.)			regarding K211 and the		
		occupancy fire safety plan and		requirement to maintain a	a 60-inch	
	1 1	ddress the relocation of the		egress in corridors and w		
		t during a fire or similar		equipment to be moved of		
	emergency.	5		fire or similar emergency	-	
		uipment is limited to the		completed with facility sta		
	following:			8/25/22.How will you ide		
	i. Equipment in use	and carts in use		other residents having t	-	
	ii. Medical emergency equipment not in use			potential to be affected		
	I	transport equipment		same deficient practice	-	
		tice could affect all residents,		what corrective action v		
	_	needing to exit the facility.		taken? A revie		
	starr and visitors in	needing to exit the facility.		facility that egresses are		
	Findings include:			K211 was completed on		
	i manigs metade.			No concerns were identif		
	Based on review of	E"Emergency Operations Plan:		What measures will be		
		ergency Action Plan" (E.O.P.)		place or what systemic	put into	
	_	n the Maintenance Supervisor		changes you will make	to	
		Nursing (D.O.N.) during record		ensure that the deficien		
		a.m. to 12:55 p.m. on 08/16/22,				
		ety plan did not address the		The EOP binder was upo		
		ed equipment during a fire or		match the EOP electronic		
		The aforementioned fire safety		Items are stored out of co		
	plan is part of the fa	-		ensure a 60-inch egress	OTTIGOTS TO	
		ram documentation which was		throughout the facility	The	
		most recent review occurring		1 -		
		d on interview at the time of		Maintenance Supervisor/	-	
		D.O.N. did a key word search		will audit of facility egress		
		nent on a computer file version		ensure a 60-inch egress		
		nent on a computer the version n was dated 02/04/19. Based on		corridors. This audit will be		
		n was dated 02/04/19. Based on the of interview at the time of		completed daily X 2 week		
				weekly X 6 weeks, then r	- I	
	·	D.O.N. and the Maintenance		10 months. The results w		
	-	the reference to relocating		documented on K211/K7		
		t in the computer file version		Tool Any discrepa	•	
		not included in the current		be immediately corrected		
	written fire safety p	olan documentation dated		the corrective action (s)	will be	

09/20/21.

monitored to ensure the

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155462	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	COMI	E SURVEY PLETED 6/2022	
	PROVIDER OR SUPPLIER	D REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 1023 W MAIN ST VEVAY, IN 47043				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE )	(X5) COMPLETION DATE	
	Supervisor during a p.m. to 2:45 p.m. or stored in the corridor. Room 106 and was extended 28 inches corridor. A Hoyer corridor outside Room 104 a blood pressure devi across from the 300 Wheelchairs which the corridor outside 302 and Room 306. of the observations, agreed the aforement wheeled equipment egress free from observations.	viewed with the Maintenance		deficient practice w recur, i.e., what qua assurance program into place?- TI Director/designee wi K211 audit records to audit has been comp documented. The EI will complete these r monthly X 12 months results of the ED/des will be forwarded to to committee for review recommendation Non-compliance will including use of prog discipline up to and i termination.	will be put the Executive ill review the o ensure the oleted and D/Designee reviews s The signee review the QAPI w and be addressed gressive		
K 0222 SS=E Bldg. 01	be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lock clinical security need, only one locking arresponding to the special lock clinical security one lock special lock special lock clinical security one lock special lock spec	d means of egress shall not a latch or a lock that f a tool or key from the susing one of the following angements: SOR SECURITY THREAT king arrangements for the eds of the patient are king device shall be door and provisions shall					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155462	B. W	ING		08/16/2022	
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1023 W	MAIN ST		
SWISS V	ILLA NURSING AN	ID REHABILITATION			, IN 47043		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		apid removal of occupants					
	1 -	l of locks; keying of all					
		ied by staff at all times; or					
		e means available to the					
	staff at all times.						
		.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6						
	SPECIAL NEEDS						
	ARRANGEMENT						
		king arrangements for the					
	1	e patient are used, all of					
		curity Locking requirements					
		addition, the locks must be					
		at fail safely so as to					
	I -	of power to the device; the					
		ed by a supervised					
	-	er system and the locked					
		d by a complete smoke					
	1	(or is constantly monitored cation within the locked					
		the sprinkler and detection nged to unlock the doors					
	upon activation.	iged to dillock the doors					
	18.2.2.2.5.2, 19.2	2 2 5 2 TIA 12.4					
	DELAYED-EGRE						
	ARRANGEMENT						
		lelayed-egress locking					
	1	in accordance with					
	7.2.1.6.1 shall be						
		ig low and ordinary hazard					
		ngs protected throughout by					
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle						
	18.2.2.2.4, 19.2.2						
	ACCESS-CONTR						
	LOCKING ARRAN						
		d Egress Door assemblies					
		lance with 7.2.1.6.2 shall					
	be permitted.	-					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		lì í	ULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155462	B. W	ING		08/16/2022	
	PROVIDER OR SUPPLIER	ID REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 1023 W MAIN ST VEVAY, IN 47043			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
TAG	18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblie throughout by an a automatic fire dete approved, supervi system.  18.2.2.2.4, 19.2.2. Based on observatic failed to ensure the 11 exits were readil without a clinical di security measures. of egress shall not b lock that requires th egress side unless o Section 19.2.2.2.4. shall be permitted in This deficient pract residents, staff and facility by using the the facility in the M  Findings include:  Based on observatic Supervisor during th facility from 9:55 a exit door set to the o Main Dining Room code into a keypad code was not posted on observations wit at 2:20 p.m. on 08/1 outside of the facilit still did not have the	2.4 BY EXIT ACCESS NGEMENTS t access door locking in 7.2.1.6.3 shall be permitted es in buildings protected approved, supervised ection system and an sed automatic sprinkler  2.4 on and interview, the facility means of egress through 1 of y accessible for residents iagnosis requiring specialized Doors within a required means be equipped with a latch or the use of a tool or key from the therwise permitted by LSC Door-locking arrangements in accordance with 19.2.2.2.5.2. ice could affect over 20 visitors if needing to exit the e exit door set to the outside of	K 0		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  No residents, staff or visitors were affected by the alleged deficient practice.  Education regarding K2 and requirement for signage to aide in coding out of exit doors was completed with facility state on 8/25/22.  How will you identify other residents having the potentiate to be affected by the same deficient practice and what corrective action will be taken and the corrective action will be taken as a review of the facility of the exit doors was completed on 8/25, to ensure signage to aide in coding out of the exit doors was present. No concerns were identified.  What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?	09/01/2022 n 222 o saff al en? exit /22	

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

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155462	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	COMP	E SURVEY LETED 6/2022
	PROVIDER OR SUPPLIER	ID REHABILITATION	1023 \	ADDRESS, CITY, STATE, ZIP C W MAIN ST Y, IN 47043	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE IPPROPRIATE	(X5) COMPLETION DATE
	keypad which releated Based on interview observations, the Monot all residents in a diagnosis to be in a agreed the code was set to the outside of Dining Room.	aintenance Supervisor stated he facility have a clinical secure wing or facility and s not posted at the exit door the facility in the Main viewed with the Maintenance		exits reflecting exit codinstructions.  The Maintenanc Supervisor/designee with that signs reflecting exinstructions are present doors. The review will completed weekly X 8 monthly X 10 months. will be documented on Audit Tool.  Any discrepancy immediately corrected. How the corrective active will be monitored to exist deficient practice will recur, i.e., what qualit assurance program with the place?  The Executive Director/designee will recur, i.e., what qualit assurance program with place?  The Executive Director/designee will recur, i.e., what qualit assurance program with place?  The Executive Director/designee will recur, i.e., what qualit assurance program with place?  The Executive Director/designee will recurred to the QAPI for review and recommon Non-compliance addressed including us progressive discipline to including termination.	e vill review it code at at all exit be weeks, then The results the K222 vill be vill be vill be vill be put vill be put vill be put vill be committee endation. It will be se of	
K 0281 SS=E Bldg. 01	discharge, is arra	_				

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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 COMPLETED 01 B. WING 155462 08/16/2022 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 or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility K 0281 09/01/2022 What corrective action(s) will failed to ensure egress lighting for 1 of 11 exit be accomplished for those means of egress was arranged so the failure of residents found to have been any single lighting fixture (bulb) would not leave affected by the deficient the area in darkness. LSC 7.8.1.4 requires practice? illumination shall be arranged so that that the No residents, staff or failure of any single lighting unit does not result visitors were affected by the in an illumination level of less than 0.2 foot-candle alleged deficient practice. in any designated area. This deficient practice Education regarding K281 could affect over 10 residents, staff and visitors if illumination of means of egress exiting the facility from the 500 Hall. was completed with facility staff on 8/25/22. Findings include: How will you identify other residents having the potential Based on observations with the Maintenance to be affected by the same Supervisor during a tour of the facility from 12:55 deficient practice and what p.m. to 2:45 p.m. on 08/16/22, one of two light corrective action will be taken? bulbs in the exit means of egress outside the 500 A review was completed on Hall exit door nearest the Therapy Room corridor 8/25/22 to ensure no issues with door was burned out. Based on interview at the illumination of means of egress. time of the observations, the Maintenance No concerns were identified. Supervisor agreed one of the two light bulbs in What measures will be put into the aforementioned exit discharge was burned out. place or what systemic changes you will make to This finding was reviewed with the Maintenance ensure that the deficient Supervisor during the exit conference. practice does not recur? The two light bulbs on the 3.1-19(b)500-hall outside the Therapy Gym were replaced prior to surveyor exit on 8/16/2022. The Maintenance Supervisor/designee will audit that illumination means of egress are in good repair with no burnt-out bulbs or issues. This review will be completed weekly X 12 months.

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The results of this review will be

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	OF CORRECTION	IDENTIFICATION NUMBER  155462	A. BUILDING B. WING	01	COMPLETED 08/16/2022
	ROVIDER OR SUPPLIER	D REHABILITATION	1023 W	ADDRESS, CITY, STATE, ZIP COD / MAIN ST /, IN 47043	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0321 SS=F Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-a do not exceed 48 if the door.	- Enclosure are protected by a fire our fire resistance rating rated doors) or an aguishing system in 7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting is in accordance with 8.4.		documented in TELS.  Any discrepancy will be immediately corrected.  How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place?  The Executive Director/designee will review records monthly X 12 months.  The results of the ED/designee review will be forwarded to the QAPI comm for review and recommendati.  Non-compliance will be addressed including use of progressive discipline up to a including termination.	the  put  TELS  ittee on.

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Facility ID: 000494

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DA		(X3) DATE	DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155462	B. W	ING _		08/16/2022	
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			/ MAIN ST		
SWISS V	III A NURSING AN	ND REHABILITATION			, IN 47043		
	ILL ( NOROING AI	TO ICE INDICITION		VEVAI	, 71070		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	A	Automotic Orginalian					
	Area	Automatic Sprinkler					
		N/A I-Fired Heater Rooms					
		er than 100 square feet)					1
		nance, and Paint Shops					
		ooms (exceeding 64					
	gallons)	come (exocoding of					
	e. Trash Collection Rooms (exceeding 64 gallons)						
	1 '	orage Rooms/Spaces					
	(over 50 square fe	- ·					
		classified as Severe					
	Hazard - see K32						
	•	on and interview, the facility	K 0	321	What corrective action(s) wil	II	09/01/2022
	failed to ensure 1 or	f over 10 hazardous areas such			be accomplished for those		
		rooms were separated from			residents found to have been	n	
		oke resistant partitions and			affected by the deficient		
		be self closing or automatic			practice?		
	_	ice with 7.2.1.8. This deficient			No residents, staff or		
	1 ^	et all residents, staff and			visitors were affected by the		
	visitors.				alleged deficient practice.		
	Findings! 1 1				· Education regarding K3		
	Findings include:				smoke barriers must separate	!	
	Rosed on absorbed	ons with the Maintenance			other spaces from hazardous		
		ons with the Maintenance a tour of the facility from 12:55			areas was completed with the		1
		n 08/16/22, numerous holes and			Maintenance Supervisor on 8/25/22.		
	1 ^	s were noted in the ceiling of			How will you identify other		
		al Room. The Main			residents having the potentia	al	1
		contained the facility's main			to be affected by the same	uı	
		rcuit breaker panels for			deficient practice and what		
	_	on the emergency generator			corrective action will be take	n?	
	I	e facility's dry sprinkler system			A review was completed		
		echanical Room also contained			8/25/22 to ensure hazardous	_ 011	
		water heater. The annular			areas are separated from other	er	
		numerous metal conduits			areas. No concerns were		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155462	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/16/2022	
	ROVIDER OR SUPPLIER	D REHABILITATION		1023 W	ADDRESS, CITY, STATE, ZIP COD MAIN ST , IN 47043		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
TAG	penetrating the ceili mounted electrical process. Fuse Box" were not space surrounding the pipe which penetrate firestopped. The anceiling mounted sproprinkler system rischole was noted in the room above the corn was also not firestop the time of the obsest of the aforementioned hazardous areas from resistant partitions as	ng of the room above the wall canel identified as "Mickey's firestopped. The annular the dry sprinkler system riser ed the ceiling was also not mular space surrounding a inkler which was near the ter exposed the attic above. A the ceiling in the corner of the cridor door to the room which toped. Based on interview at revations, the Maintenance the openings in the ceiling of the room did not separate this mother spaces with smoke and doors.		TAG	identified.  What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?  The identified conduits ceiling penetrations in the material mechanical room are fire stopped/sealed.  The Maintenance Supervisor/designee will aud penetrations are sealed to convit with K321. This review will be completed monthly X 12 more The results of this audit will be documented on the K321/K3 Audit Tool.  Any discrepancy will be immediately corrected.  How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place?  The Executive  Director/designee will review K321/K372 Audit Tool month 12 months.  The result forwarded to the QAPI commented for review and recommendat.  Non-compliance will be addressed including use of progressive discipline up to a including termination.	and ain  it that simply eaths. see 72  e the the ly X is of one sittee ion. see	DATE
			- 1				]

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155462	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/16/2022
	PROVIDER OR SUPPLIER	D REHABILITATION	1023 V	ADDRESS, CITY, STATE, ZIP COD V MAIN ST Y, IN 47043	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkler are inspected, tes accordance with Nappection, Testing Water-based Fire Records of system inspection and test secure location are a) Date sprinkler.  b) Who provided c) Water system Provide in REMAR coverage for any reautomatic sprinkler automatic sprinkler 9.7.5, 9.7.7, 9.7.8, 1. Based on record facility failed to massystems in accordance requires all sprinkle tested, and maintain 25, Standard for the Maintenance of Wasystems. NFPA 25 states the property of representative shall or impairments that inspection, test and standard. Correction performed by qualified contractor records shall be made available ma	supply source  RKS information on non-required or partial er system.  and NFPA 25 review and interview, the intain automatic sprinkler are with NFPA 25. LSC 9.7.5 r systems shall be inspected, and in accordance with NFPA inspection, Testing, and ter-Based Fire Protection , 2011 Edition, Section 4.1.4.1	K 0353	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  No residents, staff or visitors were affected by the alleged deficient practice.  Education regarding K38 sprinkler system maintenance was completed with the Maintenance Supervisor on 8/25/22.  How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taked.  A review was completed.	53 I 1 <b>?</b>

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Event ID:

 $V2XA21 \qquad {\tt Facility\ ID:} \quad 000494$ 

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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 <u>01</u> COMPLET			ETED	
		155462	B. Wl	NG		08/16/2022	
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEF	₹			MAIN ST		
SWISS V	II I A NI IRSING AN	ID REHABILITATION			, IN 47043		
	ILLA NONOING AN	NETIADILITATION		V L V A I	, 114 77 070		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPR		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
		dents, staff, and visitors in the			8/25/22 to ensure recommend		
	facility.				sprinkler repairs are completed	d.	
					No concerns were identified.		
	Findings include:				What measures will be put in	ito	
		Sa e a a e e			place or what systemic		
		the sprinkler system			changes you will make to		
	-	or's "Form for Inspection,			ensure that the deficient		
	_	nance of Dry Pipe Fire			practice does not recur?		
	*	documentation dated 04/04/22			The recommended repa		
		ce Supervisor during record			to the AMD was completed by		
		a.m. to 12:55 p.m. on 08/16/22,			facility vendor (IEI) on 8/31/22		
	deficiencies were noted for the facility's sprinkler				The ceiling tile around the Exit		
	system during the inspection for the facility. The				sign conduit outside the 200-h	all	
	-	ary" section of the 04/04/22			spa was repaired on 8/25/22.		
	-	spection report stated "Air			· The Maintenance		
		e is out of service and needs to			Supervisor/designee will audit		
	-	d on interview at the time of			sprinkler repairs are completed	d as	
		Maintenance Supervisor			recommended to comply with		
		ed "Capital Expenditure			K353. This review will be		
	_	11/22 to replace the air			completed monthly X 12 mont		
		but stated the replacement			The results of this audit will be		
	device has not yet b	peen installed.			documented on the K353 Aud	it	
		t dad set			Tool.		
	_	viewed with the Maintenance			· Any discrepancy will be		
	-	he exit conference. Based on			immediately corrected.		
		e of the exit conference, the			How the corrective action (s)		
	Maintenance Super				will be monitored to ensure t	ne	
		e does function and is			deficient practice will not		
	operating correctly	but has not been replaced.			recur, i.e., what quality		
	2.1.10/1->				assurance program will be p	ut	
	3.1-19(b)				into place?		
	2 Dagad1	ation and intermiers d f 11t-			· The Executive	<b>.</b> .	
		ation and interview, the facility			Director/designee will review t		
		he ceiling construction in the			K353 Audit Tool monthly X 12		
		noke compartments. NFPA 13,			months. The results of	ше	
	· ·	on 3.3.5.4 defines a smooth			ED/designee review will be	·	
		ous ceiling free from			forwarded to the QAPI commit		
		rities, lumps, or indentations.			for review and recommendation	III.	
		ot air and gases around the			· Non-compliance will be		

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

PRINTED: 08/28/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155462	B. W	ING		08/16/	2022
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				MAIN ST		
CM/ICC M	II I A NILIDOINIC AN	D DELIABILITATION					
SWISS V	ILLA NURSING AN	D REHABILITATION		VEVA1	, IN 47043		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	specified temperatur	re. Section 8.5.4.1.1 states the			progressive discipline up to an	d	
	distance between th	e sprinkler deflector and the			including termination.		
	ceiling above shall l	be selected based on the type					
	of sprinkler and the	type of construction. This					
	deficient practice co	deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the Spa by Room 202.					
	staff, and visitors in						
	Room 202.						
	Findings include:  Based on observations with the Maintenance						
		tour of the facility from 12:55					
	-	n 08/16/22, a two inch in					
	• •	noted in the suspended ceiling					
		ign in the corridor above the					
		the Spa by Room 202. The					
	_	ectrical conduit for the exit					
	_	rview at the time of the					
	_	aintenance Supervisor agreed					
		the suspended ceiling tile					
		by the Spa by Room 202.					
	above the exit sign (	by the spa by recoin 202.					
	This finding was rev	viewed with the Maintenance					
	Supervisor during the						
	1 8						
	3.1-19(b)						
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
Diag. 01		corridor openings in other					
		osures of vertical openings,					
	-	s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
		g fire for at least 20					
	•	fully sprinklered smoke					
		only required to resist the					
	-	. Corridor doors and doors					
	to rooms containing						
	w rooms comailli	ig naminabic oi	1				

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Event ID:

V2XA21 Facility ID: 000494

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

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155462	(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION NG <u>01</u>	(X3) DATE SURVEY COMPLETED 08/16/2022
	PROVIDER OR SUPPLIER	ID REHABILITATION	102	REET ADDRESS, CITY, STATE, ZIP COD 23 W MAIN ST EVAY, IN 47043	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPRO	OBE COMPLETION
	hardware. Roller la CMS regulation. Tapply to auxiliary signammable or com Clearance between covering is not except doors complying wife provided with a control the door closed with applied. There is closing of the door release when the permitted. Nonrate unlimited height and meeting 19.3.6.3.6 frames shall be lad other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies.  19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection rating devices, etc. Based on observation failed to ensure 4 of impediment to closi frame and would resistance and would resistance and some control to the control that the contro	en bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are ed protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3,	K 0363	What corrective action(s) be accomplished for thos residents found to have be affected by the deficient practice?	e
	residents, staff and Findings include:	visitors.		No residents, staff o visitors were affected by th alleged deficient practice.     Education regarding	K363

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/16/2022 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Supervisor during a tour of the facility from 12:55 and latching of doors can exist in p.m. to 2:45 p.m. on 08/16/22, the ceiling mounted the facility. Staff were education to track for the privacy curtain for the resident bed store privacy curtains at the far nearest the corridor door was installed such that end of resident rooms (opposite the privacy curtain was in the path of the swing of the doorway) or behind the curtain the corridor door to resident Room 204, Room 206, retainers inside the doorway such Room 302 and Room 308. The privacy curtain was that the privacy curtains do not fully opened in each room and prevented the obstruct the swinging path of the corridor door to each of the four resident sleeping doorway. This education was rooms from fully closing and latching into the completed with facility staff on door frame. In addition, the resident bed nearest 8/25/22. the corridor door to Room 302 was also in the How will you identify other swing of the path of closure for the door and also residents having the potential prevented the door from closing and latching into to be affected by the same the door frame. Based on interview at the time of deficient practice and what the observations, the Maintenance Supervisor corrective action will be taken? agreed the privacy curtain in the aforementioned A review was completed on rooms were hung in the path of the swing of the 8/25/22 to ensure no impediments corridor door to the room and would not ensure to closing and latching of doors the door would close and latch into the door exists. Concerns were frame. immediately corrected. What measures will be put into This finding was reviewed with the Maintenance place or what systemic Supervisor during the exit conference. changes you will make to ensure that the deficient 3.1-19(b) practice does not recur? Curtain retainers were installed in resident rooms to allow for privacy curtains to be stored out of the swing path of doorways. The Maintenance Supervisor/designee will audit that no impediments to closing and latching of doors exist. This review will be completed weekly X 8 weeks, then monthly X 10 months. The results of this audit will be documented on the K363 Audit Tool. Any discrepancy will be

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

PRINTED: 08/28/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155462	(X2) MULTIPLE C A. BUILDING B. WING	onstruction  01	(X3) DATE SURVEY COMPLETED 08/16/2022
	ROVIDER OR SUPPLIER	D REHABILITATION	1023 V	ADDRESS, CITY, STATE, ZIP COD V MAIN ST Y, IN 47043	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	N (X5) SEE COMPLETION DATE
K 0372	NFPA 101			immediately corrected.  How the corrective action (will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place?  The Executive  Director/designee will review K363 Audit Tool monthly X months. The results of ED/designee review will be forwarded to the QAPI common for review and recommendated Non-compliance will be addressed including use of progressive discipline up to including termination.	e the  e put  w the 12 of the  mittee ation. oe
SS=F Bldg. 01	Subdivision of Bui Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be patrium wall. Smoke in duct penetration systems where and is installed for smoke barrier 19.3.7.3, 8.6.7.1(1) Describe any medical system in REMAR	pall be constructed to a stance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.  ) hanical smoke control	K 0372	What corrective action(s) v	will 09/01/2022
	failed to ensure ope	nings through 1 of 1 ceiling protected to maintain the fire	K 03/2	be accomplished for those residents found to have be	

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Event ID:

V2XA21

Facility ID: 000494

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	r of health and hui r medicare & medic						RM APPROVED B NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(V2) MIII	TIDI E CC	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI		01	COMPL	
AND PLAN	OF CORRECTION	155462	B. WIN		01	08/16/2022	
		199402	D. WIN	<u> </u>		06/10/	2022
NAME OF E	PROVIDER OR SUPPLIEF	,		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	KOVIDEK OK SUITEIEF			1023 W	MAIN ST		
SWISS V	ILLA NURSING AN	ID REHABILITATION		VEVAY	, IN 47043		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	resistance rating of	the smoke barrier. LSC			affected by the deficient		
	19.3.7.3 refers to Se	ection 8.5. Section 8.5.6.2 states			practice?		
	penetrations for cal	oles, conduits, pipes and			· No residents, staff or		
	similar items that p	ass through a floor/ceiling			visitors were affected by the		
	assembly constructe	ed as a smoke barrier, or			alleged deficient practice.		
	through the ceiling	membrane of a ceiling smoke			Education regarding K3	72	
	barrier shall be prot	ected by a system or material			smoke barriers must separate		
	capable of resisting	the transfer of smoke. Where			other spaces from hazardous		
	a smoke barrier is a	lso constructed as a fire barrier,			areas was completed with the		
	the penetrations sha	all be protected in accordance			Maintenance Supervisor on		
	with the requiremen	nts of Section 8.3.5 to limit the			8/25/22.		
	spread of fire for a	time period equal to the fire			How will you identify other		
	resistance of the ass	sembly and Section 8.5.6. This			residents having the potentia	al	
	deficient practice co	ould affect all residents, staff			to be affected by the same		
	and visitors.				deficient practice and what		
					corrective action will be take	n?	
	Findings include:				<ul> <li>A review was completed</li> </ul>	d on	
					8/25/22 to ensure smoke barri	ers	
	Based on observation	ons with the Maintenance			are sealed per K372. Concern	ıs	
	Supervisor during a	tour of the facility from 12:55			were immediately corrected.		
		n 08/16/22, numerous holes and			What measures will be put in	ito	
	ceiling penetrations	were noted in the ceiling of			place or what systemic		
	the Main Mechanic	al Room. The Main			changes you will make to		
	Mechanical Room	contained the facility's main			ensure that the deficient		
	electrical panels, ci	rcuit breaker panels for			practice does not recur?		
		n the emergency generator			<ul> <li>The identified conduits a</li> </ul>	and	
	and also housed the	facility's dry sprinkler system			ceiling penetrations in the mai	n	
		echanical Room also contained			mechanical room and the attic	;	
	I -	vater heater. The annular			access outside of medical rec	ords	
		numerous metal conduits			office were fire stopped/sealed	d.	
		ing of the room above the wall			· The Maintenance		
		panel identified as "Mickey's			Supervisor/designee will audit		
		t firestopped. The annular			penetrations are sealed to cor	nply	
		he dry sprinkler system riser			with K372. This review will be		
		ted the ceiling was also not			completed monthly X 12 mont		
		nnular space surrounding a			The results of this audit will be		
	-	rinkler which was near the			documented on the K/321/K37	72	
	sprinkler system ris	er exposed the attic above. A			Audit Tool.		

hole was noted in the ceiling in the corner of the

room above the corridor door to the room which

V2XA21

immediately corrected.

Any discrepancy will be

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

STATEMENT OF AND PLAN OF CO		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155462	(X2) MULTIP A. BUILDIN B. WING			COM	TE SURVEY TPLETED 16/2022
	TIDER OR SUPPLIER	D REHABILITATION	10:	EET ADDRE 23 W MAII VAY, IN 4		COD	
SWISS VILLA  (X4) ID PREFIX TAG  was the Su the haz res  Th Su  3.1  2. fai pro sm wi ho coi the Re  Fin  Ba Su p.r inc sm	SUMMARY S  (EACH DEFICIENCE REGULATORY OR  as also not firestope the time of the observations are as from the sistant partitions a sistant partitions and the sistant partitions are approvisor during the sistant partitions and the sistant partitions are approvisor during the sistant partitions and the sistant partitions are approvisor during the sistant partitions are approvisor during the sistant partitions are sistant partitions and the sistant partitions are sista	D REHABILITATION  TATEMENT OF DEFICIENCIE  TY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION  ped. Based on interview at vations, the Maintenance the openings in the ceiling of froom did not separate this in other spaces with smoke and doors.	STF 102	AND MAII VAY, IN 4  IX CR  How will defirect ass into .  Direct K32 12 r the forw for r .  add prog	PROVIDER'S PLAN OF COEACH CORRECTIVE ACTION OSS-REFERENCED TO THI DEFICIENCY  W the corrective as be monitored to icient practice wi ur, i.e., what qual surance program o place? The Executive ector/designee will 21/K372 Audit Too	DORRECTION ISHOULD BE EAPPROPRIATE  action (s) ensure the fill not lity will be put  I review the polymorthy X are results of ew will be put lity in a committee imendation. The committee imendation is easily to and	(X5) COMPLETION DATE
gra con int Ma afo bar	ay cables. The an induit was also not terview at the time aintenance Superv orementioned open	nings in the attic smoke t protected to maintain the fire					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155462	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/16/2022
	PROVIDER OR SUPPLIER	D REHABILITATION	1023 V	ADDRESS, CITY, STATE, ZIP COD V MAIN ST Y, IN 47043	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
0	This finding was re Supervisor during the	viewed with the Maintenance			22
K 0521 SS=F Bldg. 01	comply with 9.2 ar accordance with the specifications.  18.5.2.1, 19.5.2.1, Based on record revinterview; the facility dampers in the facility dampers in the facility recent four year per 90A. LSC 9.2.1 recair conditioning (H'equipment shall be Standard for the Instance of Instance of the Instance of Inspector and Instance of Inspector and Inspector of Ins		K 0521	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  No residents, staff or visitors were affected by the alleged deficient practice.  Education regarding K52 requirement for 4-year inspection of HVAC dampers was comple with the Maintenance Supervision 8/25/22.  How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken.  A review was completed 8/25/22 to ensure documentation of the March 20, 2020 completed damper inspection is on file an available for review at the facility what measures will be put into place or what systemic changes you will make to ensure that the deficient	21 ons sted sor  I on on ed d d ity.

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Event ID:

V2XA21 Facility ID: 000494

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	01	COMPL	ETED
		155462	B. WIN	G		08/16/	2022
		<u> </u>	<del>'                                    </del>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEI	R			MAIN ST		
SWISS V	ILLA NURSING AN	ND REHABILITATION			, IN 47043		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ll be verified and corrected as			practice does not recur?		
	•	cient practice could affect all			<ul> <li>The next 4-year dampe</li> </ul>	r	
	residents, staff and	visitors.			inspection will be completed p	rior	
					to March 2024.		
	Findings include:				· The Maintenance		
					Supervisor/designee will revie	W	
		view with the Maintenance			that record of the 3/20/22		
	Supervisor from 10:15 a.m. to 12:55 p.m. on 08/16/22, documentation of fire damper				inspection is on file in the Life		
					Safety Binder and available fo	r	
	-	ted within the most recent four			review. The Maintenance		
		t available for review. Based			Supervisor/designee will ensu		
		he time of record review, the			the next inspection is complete	ed	
	_	visor provided a "Fire			prior to March 2024 and		
	• •	for the facility which listed two			documentation of the damper		
	_	ns in the facility but the			inspections is recorded in TEL	_S Q	
	_	visor agreed the floor plan			4 years.		
		not provide the date of the			· Any discrepancy will be		
	most recent inspect	<u>-</u>			immediately corrected.		
		ed on observations with the			How the corrective action (s)		
		rvisor during a tour of the			will be monitored to ensure t	ine	
	-	p.m. to 2:45 p.m. on 08/16/22,			deficient practice will not		
		damper locations which were "Fire Damper" floor plan were			recur, i.e., what quality	4	
		tion affixed to the fire damper			assurance program will be p	ut	
		in the corridor outside Room			into place? The Executive		
		ductwork in the sitting area in			Director/designee will review t	hat	
		om 500 did not provide the date			4-year damper inspections are		
	-	inspection and necessary			completed Q 4 years and	•	
		ed on interview at the time of			documentation of the inspection	one	
		of the observations, the			are on hand in TELS and facil		
		rvisor agreed documentation of			Life Safety Binder. The	-	
	_	tions conducted within the			results of the ED/designee rev		
		ear period was not available for			will be forwarded to the QAPI		
	review.	r			committee for review and		
	. ==				recommendation.		
	This finding was re	eviewed with the Maintenance			· Non-compliance will be		
	Supervisor during t				addressed including use of		
	1				progressive discipline up to ar	nd	
	3.1-19(b)				including termination.	•	
i l	l '		1				

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

PRINTED: 08/28/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155462	A. BUILDING B. WING	01	COM	IPLETED 16/2022
	ROVIDER OR SUPPLIER ILLA NURSING AN	D REHABILITATION	1023 W	address, city, state, zii / MAIN ST /, IN 47043	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
				We respectfully requested with the citation of the completed. A record hand on the date of Safety inspections are contimely and the inspections are contimely and the inspections. The 2567 a Fire Damper Floor such record exists document reference handwritten note-net facility record. A syplace to ensure time completion of these The facility staff are alented for and completed prior to learn the facility staff are alented for the completed prior to learn the facility record. The facility staff are alented for and completed prior to learn the facility staff are alented for the facility staff are alented facility staff are alented for the facility staff are alented facili	on. We in be deleted. in facility was id was on if the Life The 4-year inpleted ections ify all if references if Plan. No ithe ed was a of an official ystem is in ely e inspection. ELS PM ensure the red to the ete the is timely. The be March 2024 if the	
K 0711 SS=F Bldg. 01	patients and for the of an emergency. Employees are perkept informed with and a copy of the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

V2XA21

Facility ID: 000494

If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155462	B. W	ING		08/16/	2022
	PROVIDER OR SUPPLIER	ID REHABILITATION	-	1023 W	ADDRESS, CITY, STATE, ZIP COD / MAIN ST /, IN 47043		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEDIS DI AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE
TAG	of staff per 18/19. of the fire safety p 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3, 19.7.2.1.2, 19.7.2. Based on record revinterview; the facili plan that addressed written fire plans. I health care occupan provide for the follo (1) Use of alarms (2) Transmission of (3) Emergency phoro (4) Response to alar (5) Isolation of fire (6) Evacuation of ir (7) Evacuation of si (8) Preparation of fi evacuation (9) Extinguishment Section 19.2.3.4(4) width shall be perm provided that all of met:  (a) The wheeled equipment clear unobstructed of inches.  (b) The health care training program adwheeled equipment emergency.  (c) The wheeled equipment in use ii. Medical emergeriii. Patient lift and the safety of the sa	7.2.1.2 and provides for all lan components per  8.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 2, 19.7.2.3 riew, observation and ty failed to provide a written all components in 1 of 1 LSC 19.7.2.2 requires a written cy fire safety plan that shall owing:  Calarm to fire department the call to fire department me call to fire department cors and building for  of fire Projections into the required itted for wheeled equipment, the following conditions are  suppment does not reduce the corridor width to less than 60  occupancy fire safety plan and dress the relocation of the during a fire or similar  sipment is limited to the and carts in use acy equipment not in use	K 0		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  No residents, staff or visitors were affected by the alleged deficient practice.  Education regarding K7 that no items may be stored in corridors, the fire safety plan identifies the location of smok doors, and the EOP evacuation procedure addresses wheeled equipment procedure during a emergency. This education wo completed with facility staff on 8/25/22.  How will you identify other residents having the potentiation be affected by the same deficient practice and what corrective action will be taked.  A review was completed 8/25/22 to ensure no items are stored in corridors, the fire safe plan was updated to identify the location of smoke/fire doors, at the EOP binder was updated to identify the include evacuation proceded for wheeled equipment during emergency. Concerns were immediately corrected.  What measures will be put in	III  n  f11  n e/fire on d an /as n al en? d on e fety he and to dure an dure	DATE  09/01/2022

PRINTED: 08/28/2023

	Γ OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155462	l í	ULTIPLE CONSTRUCTION (X3) DATE SUR UILDING 01 COMPLETE		SURVEY ETED	
	PROVIDER OR SUPPLIER	ID REHABILITATION	•	1023 W	ADDRESS, CITY, STATE, ZIP COD V MAIN ST V, IN 47043		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Fire/Explosion Emedocumentation with and the Director of review from 10:15: the written fire safe relocation of wheelesimilar emergency. plan is part of the far Preparedness Progradocumented as the on 09/20/21. Based record review, the I for wheeled equipm of the E.O.P. which interview at the tim record review, the I Supervisor agreed the wheeled equipment dated 02/14/19 was written fire safety proposed to 109/20/21.  In addition the writter facility dated 09/20 evacuated during a necessary, through fire safety plan doculocation of smoke of Based on interview the D.O.N. and the agreed the current with the safety proposed to the current with the current with the safety proposed to the current with the safety proposed to the current with the current with the safety proposed to the current with the c	am documentation which was most recent review occurring I on interview at the time of D.O.N. did a key word search tent on a computer file version was dated 02/04/19. Based on the of D.O.N. and the Maintenance the reference to relocating in the computer file version not included in the current lan documentation dated  ten fire safety plan for the word of the did the fire or similar emergency, if semoke or fire doors but the time of record review, at the time of record review, Maintenance Supervisor written fire safety plan for the under the location of smoke or			place or what systemic changes you will make to ensure that the deficient practice does not recur?  The identified items wer removed from corridors, the E binder was updated to include location of smoke/fire doors in fire safety plan, the EOP binder was updated to include proper handling of wheeled equipmer during an evacuation or similal emergency.  The Maintenance Supervisor/designee will audit corridors remain free of stored items and complies with K711 This review will be completed X 2 weeks, weekly X 6 weeks, then monthly X 10 months. The results of this audit will be documented on the K211/K281/K711 Audit Tool.  Any discrepancy will be immediately corrected.  How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place?  The Executive Director/designee will review the K211/K281/K711 Audit Tool monthly X 12 months.	op the er ht that daily he	

Based on observations with the Maintenance

Supervisor during a tour of the facility from 12:55

p.m. to 2:45 p.m. on 08/16/22, a large Hoyer lift was

V2XA21

The results of the

forwarded to the QAPI committee

for review and recommendation.

ED/designee review will be

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155462	B. WING	<del></del>	08/16/2022
		100402	<i>B.</i> WING		00/10/2022
NAME OF D	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	ROVIDER OR SUPPLIER	· ·	1023 W	/ MAIN ST	
SWISS V	ILLA NURSING AN	ID REHABILITATION	VEVAY	′, IN 47043	
				· •	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	stored in the corrido	or up against the wall outside			
	Room 106 and was	not in use. The Hoyer lift			
		into the eight foot wide		· Non-compliance will be	
		ift was also stored in the		addressed including use of	
				_	1
		om 306. A wheeled plastic		progressive discipline up to an	ia
		as stored in the corridor		including termination.	
		and Room 208. A wheeled			
	blood pressure devi	ice was stored in the corridor			
	across from the 300	Hall nurse's station.			
	Wheelchairs which	were not in use were stored in			
	the corridor outside	Room 204, Room 208, Room			
		. Based on interview at the time			
		, the Maintenance Supervisor			
		aipment not in use was stored			
	in the corridor.	ilpinent not in use was stored			
	in the corridor.				
	_	viewed with the Maintenance			
	Supervisor during t	he exit conference.			
	3.1-19(b)				
K 0761					
SS=E					
Bldg. 01					
		view, observation and	K 0761	What corrective action(s) wil	09/01/2022
		ity failed to ensure annual		be accomplished for those	
	inspection and testi	ng of all fire door assemblies		residents found to have beer	1
	were completed in a	accordance of LSC 19.1.1.4.1.1.		affected by the deficient	
	Communicating op	enings in dividing fire barriers		practice?	
		4.1 shall be permitted only in		No residents, staff or	
		be protected by approved		visitors were affected by the	
		or assemblies. (See also Section		alleged deficient practice.	
		Openings required to have a fire		· Education regarding K7	61
		Table 8.3.4.2 shall be		that fire resistance rating plate	
		ved, listed, labeled fire door		fire doors must not be obstruc	
		window assemblies and their		with paint or other material. Th	
		lware, including all frames,		education was completed with	the
	closing devices, and	chorage, and sills in		Maintenance Supervisor on	
	accordance with the	e requirements of NFPA 80,		8/25/22.	

Standard for Fire Doors and Other Opening

How will you identify other

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01		(X3) DATE SURVEY COMPLETED 08/16/2022	COMPLETED			
	PROVIDER OR SUPPLIER	D REHABILITATION	1023 W	ADDRESS, CITY, STATE, ZIP COD / MAIN ST /, IN 47043		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMP	X5) LETION
TAG	Protectives, except Code. NFPA 80 5.2 shall be inspected a annually, and a writ shall be signed and AHJ. NFPA 80, 5.2 shall be visually ins assess the overall co NFPA 80, 5.2.4.2 st following items sha (1) No open holes of either the door or fr (2) Glazing, vision are intact and secure equipped. (3) The door, frame noncombustible thre and in working orde damage. (4) No parts are mis (5) Door clearances listed in 4.8.4 and 6 (6) The self-closing the active door com from the full open p (7) If a coordinator closes before the ac (8) Latching hardway door when it is in th (9) Auxiliary hardway prohibit operation a frame. (10) No field modif have been performed (11) Gasketing and inspected to verify to This deficient pract	r breaks exist in surfaces of ame. light frames, and glazing beads ely fastened in place, if so  , hinges, hardware, and eshold are secured, aligned, er with no visible signs of sing or broken. do not exceed clearances .3.1.7. device is operational; that is, pletely closes when operated position. is installed, the inactive leaf tive leaf. are operates and secures the	TAG	residents having the potenti to be affected by the same deficient practice and what corrective action will be take A review was complete 8/25/22 to ensure fire door rat plates are not obstructed with paint or other material. No concerns were identified. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The paint was removed from the fire resistance rating on the identified 500 hall fire of The Maintenance Supervisor/designee will audit fire door fire resistance rating plates are visible and comply K761. This review will be completed monthly X 12 mont The results of this audit will be documented on the K761 Aud Tool. Any discrepancy will be immediately corrected. How the corrective action (s will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be p into place? The Executive Director/designee will review to K761 Audit Tool monthly X 12 months. The results of the	al  en? d on ing  plate door. that with ths. elit  the  ut	ATE

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corridor door set Room 501.

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ED/designee review will be

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

PRINTED: 08/28/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155462		A. BUII B. WIN	LDING	01	COMPL 08/16/	ETED			
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD MAIN ST				
SWISS V	ILLA NURSING AN	D REHABILITATION	VEVAY, IN 47043						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE		
	Findings include:				forwarded to the QAPI commit for review and recommendatio · Non-compliance will be				
	Door Assemblies" d conducted within the period with the Main record review from 08/16/22, none of the documented any definspections were concommunities. Based Maintenance Supervisacility from 12:55 p fire resistance rating north fire door in the 501 was painted and interview at the time Maintenance Supervisating label was pain locations.	"Inspection of Swinging Fire documentation for inspections are most recent twelve month intenance Supervisor during 10:15 a.m. to 12:55 p.m. on the fire door inspections ficiencies. The fire door inducted by American Senior and on observations with the visor during a tour of the p.m. to 2:45 p.m. on 08/16/22, the glabel on the hinge side of the eccorridor door set by Room and not legible. Based on the of the observations, the visor agreed the fire resistance intended at one of the fire door wiewed with the Maintenance are exit conference.			addressed including use of progressive discipline up to an including termination.	d			
K 0923 SS=E Bldg. 01	Storag	Cylinder and Container							
	Storage Greater than or eq Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations a enclosure or within								

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Event ID:

V2XA21 Facility ID: 000494

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLET			LETED	
		155462	B. WIN	NG		08/16	/2022
NAME OF I	DDOMDED OF GUIDN 151		<del>'</del>	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF PROVIDER OR SUPPLIER				1023 W	MAIN ST		
SWISS V	ILLA NURSING AN	ND REHABILITATION		VEVAY	, IN 47043		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	NCY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		door (or gates outdoors)					
		ed. Oxidizing gases are not					
		ables, and are separated					
		s by 20 feet (5 feet if					
	1 '	closed in a cabinet of					
		onstruction having a					
		ire protection rating.					
	_ ·	al to 300 cubic feet					
	_	compartment, individual					
	_	e for immediate use in s with an aggregate volume					
	1 '	ual to 300 cubic feet are not					
	1	red in an enclosure.					
	1	e handled with precautions					
	as specified in 11	-					
		ign readable from 5 feet is					
		ate of a cylinder storage					
		sign includes the wording as					
		TION: OXIDIZING GAS(ES)					
	STORED WITHIN	I NO SMOKING."					
	Storage is planne	d so cylinders are used in					
	order of which the	ey are received from the					
	supplier. Empty of	cylinders are segregated					
	from full cylinders	. When facility employs					
	1 -	egral pressure gauge, a					
	1	e considered empty is					
	established. Emp	oty cylinders are marked to					
		Cylinders stored in the open					
	are protected from						
		.3.3, 11.3.4, 11.6.5 (NFPA					
	99)		17.00				00/01/2022
		on and interview, the facility	K 09	23	What corrective action(s) will	II	09/01/2022
	failed to ensure 4 of 9 cylinders of nonflammable gases such as oxygen were properly secured from				be accomplished for those	_	
					residents found to have been	n	
		ygen storage areas. NFPA 99, ies Code, 2012 Edition, Section			affected by the deficient		
		e for nonflammable gases			practice?		
	_	than 85 cubic meters (3000			No residents, staff or visitors were affected by the		
		mply with 5.1.3.3.2 and 5.1.3.3.3.			alleged deficient practice.		
		5.1.3.3.2(7) requires cylinders be			Education regarding K9	23	

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Event ID:

V2XA21 Facility ID: 000494

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE :			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
155462		B. W	B. WING 08/16			2022	
				CTREET	ADDRESS OF A TE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
CAMICO VILLA AND DELLA DILITATIONI				MAIN ST			
SWISS VILLA NURSING AND REHABILITATION				VEVAY	, IN 47043		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	I	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	provided with racks	s, chains, or other fastenings to			proper storage of O2 equipme	nt	
	secure all cylinders	from falling, whether			was completed with facility sta		
	connected, unconnected, full or empty. This				on 8/25/22.		
		ould affect over 10 residents,			How will you identify other residents having the potential		
	_	the vicinity of the oxygen					
		ling room by the 300 Hall			to be affected by the same		
	nurse's station.	e ,			deficient practice and what		
					corrective action will be take	n?	
	Findings include:				A review was completed on		
	, , ,				8/25/22 to ensure oxygen tank		
	Based on observation	ons with the Maintenance			were properly stored in the oxy		
		tour of the facility from 12:55			room. No concerns were ident		
		n 08/16/22, four of nine 'E' type			What measures will be put in	I	
		ere freestanding on the floor in			place or what systemic		
		and transfilling room by the			changes you will make to		
		tion and were not properly			ensure that the deficient		
	secured from falling. Five liquid oxygen				practice does not recur?		
	_	'E' type oxygen cylinders were			Stands and fixed storag	e	
		Based on interview at the time			devices are present in the oxy		
		the Maintenance Supervisor			room to ensure O2 tanks can l	_	
		gen cylinders were not			properly stored per K923.		
	-	der stand or otherwise			· The Maintenance		
		g in the oxygen storage and			Supervisor/designee will audit	that	
	•	the 300 Hall nurse's station.			oxygen tanks are properly stor		
	,				and comply with K761. This re		
	This finding was re	viewed with the Maintenance			will be completed daily X 2 we		
	Supervisor during the				weekly X 6 weeks, then month		
	supervisor during a				10 months. The results of this		
	3.1-19(b)				audit will be documented on		
	(-)				K923/K927 Audit Tool.		
					· Any discrepancy will be		
					immediately corrected.		
					How the corrective action (s)		
					will be monitored to ensure t	I	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?	u.	
					The Executive		
						he	
					Director/designee will review to	ile	

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Event ID:

V2XA21 Facility ID: 000494

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

PRINTED: 08/28/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155462		A. BUILDING B. WING	01	COMPLETED 08/16/2022				
	PROVIDER OR SUPPLIER	D REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 1023 W MAIN ST VEVAY, IN 47043					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				K923/927 Audit Tool monthly months. The results of ED/designee review will be forwarded to the QAPI commit for review and recommendation. Non-compliance will be addressed including use of progressive discipline up to an including termination.	the ttee on.			
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxyg another is in accord Transfilling of High Oxygen Used for It any gas from one prohibited in patient to liquid oxygen co containers over 50 under 11.5.2.3.1 (I liquid oxygen containers under 8	1.5.2.3.2 (NFPA 99).						
	Based on observation failed to ensure 1 of where transfilling of NFPA 99, Health C 2012 Edition, Section transfilling locations (1) A designated are of a facility wherein examined, or treated resistive construction (2) The area is meet and has ceramic or of the stream	on and interview, the facility I oxygen storage locations ceurs was in accordance with are Facilities Code. NFPA 99, on 11.5.2.3.1 states oxygen as shall include the following: the aseparated from any portion a patients are housed, I by a fire barrier of 1 hour fire on. nanically vented, is sprinklered,	K 0927	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  No residents, staff or visitors were affected by the alleged deficient practice.  Education regarding K9 oxygen trans-fill signage must present at oxygen room was completed with facility staff on 8/25/22.	27 be			

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Event ID:

V2XA21

Facility ID: 000494

If continuation sheet

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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 <u>01</u>		01	COMPLETED	
		155462	B. W	B. WING 08/16/2022			
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			/ MAIN ST		
SWISS V	ILLA NURSING AN	ID REHABILITATION			', IN 47043		
			1		,	<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION		TAG		DATE	
	-	ring and that smoking in the			How will you identify other		
	immediate area is n	-			residents having the potentia	aı	
		ransfilling the container(s) has ed in the transfilling			to be affected by the same		
	procedures.	ed in the transfirming			deficient practice and what corrective action will be take	.n2	
	•	tates in health care facilities					
		rohibited and signs are			A review was completed 8/25/22 to ensure oxygen trans		
		gically) placed at all major			signage was present at the	13-1111	
		y signs with no smoking			oxygen room. No concerns we	ere	
		be required. This deficient			identified.		
		t over 10 residents, staff and			What measures will be put in	nto	
	-	ity of the oxygen storage and			place or what systemic		
		the 300 Hall nurse's station.			changes you will make to		
					ensure that the deficient		
	Findings include:				practice does not recur?		
	S				Oxygen trans-fill signs a	are	
	Based on observation	ons with the Maintenance			posted inside and outside of the		
		tour of the facility from 12:55			oxygen room door.		
		n 08/16/22, oxygen transfilling			· The Maintenance		
	occurs in the oxyge	n storage and transfilling room			Supervisor/designee will audit	that	
	by the 300 Hall nur	se's station. Four liquid			the signs are in place to comp		
	oxygen containers a	and nine 'E' type oxygen			with K927. This review will be		
	cylinders were store	ed in the room. This			completed daily X 2 weeks,		
		was not posted with signage			weekly X 6 weeks, then month	nly X	
	-	ng occurs in the room. Based			10 months. The results of this	s	
		time of the observations, the			audit will be documented on		
	_	visor agreed the 300 Hall			K923/K927 Audit Tool.		
		transfilling room was not			· Any discrepancy will be	:	
		indicating transfilling occurs			immediately corrected.		
	in the room.				How the corrective action (s)		
		t deal and a section			will be monitored to ensure t	the	
	_	viewed with the Maintenance			deficient practice will not		
	Supervisor during the	he exit conference.			recur, i.e., what quality	<u>,                                    </u>	
	2.1.10(1)				assurance program will be p	ut	
	3.1-19(b)				into place?		
					The Executive		
					Director/designee will review t		
					K923/927 Audit Tool monthly		
					months. The results of	ine	
					ED/designee review will be		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENT		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155462	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		<u>01</u>	(X3) DATE SURVEY COMPLETED 08/16/2022	
NAME OF PROVIDER OR SUPPLIER SWISS VILLA NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 1023 W MAIN ST VEVAY, IN 47043				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION				DATE	
					forwarded to the QAPI commit for review and recommendatio  Non-compliance will be addressed including use of progressive discipline up to an including termination.	n.	

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