STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155462	A. BUILDING 00 B. WING	10/11/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the investigation of Complaints IN00417677 and IN00418465. Complaint IN00418465 - Federal/State deficiencies related to the allegations are cited at F641 and F880. Complaint IN00417677 - No deficiencies related to the allegations are cited. Survey dates: October 10 and 11, 2023 Facility number: 000494 Provider number: 155462 AIM number: 100291450 Census Bed Type: SNF/NF: 43 Total: 43 Census Payor Type: Medicare: 6 Medicaid: 32 Other: 5 Total: 43 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 13, 2023.	F 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or an agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request the Department accept this plan as our facility's compliance and request a desk review for credible compliance.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility	F 0641	It is the standard of this facility to	10/25/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kyle Stout	HFA	10/25/2023

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

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	failed to accurately complete MDS (Minimum Data Set) assessments related to residents' diagnoses of urinary tract infections for 2 of 3 residents reviewed for accuracy of assessments. (Residents F and B) Findings include: 1. A Quarterly MDS assessment, dated 09/22/23, indicated the resident was severely cognitively impaired. Section I of the assessment listed potential active diagnoses. The directions indicated staff were to check all diagnoses that applied. The diagnoses checked off as active included, but were not limited to, unspecified dementia, hypertension, and chronic kidney disease. The assessment lacked indication the resident had a UTI (urinary tract infection) in the last 30 days. An Infection Event Report, dated 08/25/23, indicated the resident had symptoms of a UTI with an onset date of 08/22/23. The symptoms included a fever or leukocytosis (an elevated white blood cell count), and a new or marked increase in incontinence. A progress note, dated 08/22/23 at 4:55 P.M., indicated the resident experienced an increased need for assistance with transfers. The resident reported increased weakness. The MD was notified. A progress note, dated 08/22/23 at 5:16 P.M., indicated the new MD orders to obtain some blood work and a UA (urinalysis). A progress note, dated 08/25/23 at 2:02 P.M., indicated the UA results were received and the MD was notified.		ensure MDS (Minimum Data Set) assessments accurately reflect the resident's status. 1 What corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident F's Quarterly MDS assessment dated 09/22/23 was modified 10/11/2023 to show the resident had a UTI (urinary tract infection) within the last 30 days. Resident B's Quarterly MDS assessment dated 09/19/23 was modified 10/11/2023 to show the resident had a UTI (urinary tract infection) within the last 30 days. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this alleged deficient practice. An audit of all MDS assessments related to UTI was completed on all residents on 10-23-23 by MDS nurse consultant to ensure all assessments accurately reflect the resident's status. 3 What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur? The float MDS coordinator was in-serviced on 10/11/2023 by the MDS Nurse Consultant regarding correct completion of all sections of the MDS (minimum data set). Starting on 10/12/23 the MDS	

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	A progress note, dated 08/25/23 at 2:14 P.M., indicated new MD orders were received and the resident was to start Keflex (an antibiotic) 500 mg (milligrams) four times a day for seven days. A progress note, dated 08/25/23 at 11:14 P.M., indicated the resident was being treated for a UTI. The resident's August 2023 EMAR (Electronic Medication Administration Record) was provided by the DON (Director of Nursing) on 10/11/23 at 2:43 P.M. The EMAR indicated the resident received cephalexin (brand name Keflex), 500 mg, four times a day for treatment of a UTI from 08/25/23 through 09/01/23. 2. During an interview and observation on 10/10/23 at 10:14 A.M., the IP (Infection Preventionist) indicated the room in the 200 Hall and the room in the 300 Hall was in isolation for E-coli in their urine. Isolation carts were sitting in the hall outside of the residents' rooms. During an observation and interview on 10/10/23 at 10:25 A.M., Housekeeper 4 donned a gown and gloves prior to entering the room that was in isolation on the 200 Hall. The housekeeper indicated Resident B was in isolation. A Quarterly MDS assessment, dated 09/19/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, schizophrenia, and hypertension. The resident required extensive assistance of two staff members for bed mobility and toileting. Section I (Active Diagnoses) of the MDS assessment, dated 09/19/23 was provided by the MDS Coordinator on 10/11/23 at 1:57 P.M. The record lacked documentation the resident had a		nurse consultant will be auditing and closing all MDS's. After being checked, all assessments will have corrections done if needed. Once completed they will then be closed and submitted to CMS. 4 How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? To ensure compliance the MDS nurse consultant and/or designee will implement a MDS (minimum data set) audit tool weekly x 4 weeks, monthly x 6 months and quarterly thereafter. MDS nurse consultant and/or designees audit of the MDS will be brought to the CQI meeting weekly by the DNS and/or designee for 6 months for review by the IDT. Results of these audits will also be brought to QAPI meeting monthly for further review and recommendations for 6 months. At the end of that time, if 100% compliance is reached, the committee may decide to stop the documented audits and the MDS nurse consultant and/or design check of the MDS. Date of compliance: 10/25/2023	

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	UTI in the last 30 days. An Infection Event Report, dated 08/29/23, indicated the resident had symptoms of a UTI with an onset date of 08/28/23. The symptoms included a fever or leukocytosis, and a new or marked increase in incontinence. The resident had a urine sample that had tested positive for E-coli and was placed on Contact Precautions (requiring staff to wear a gown and gloves when providing care). The resident received Macrobid (an antibiotic) 100 mg, from 09/01/23 to 09/07/23. The resident's September 2023 EMAR indicated the resident received Macrobid, 100 mg every 12 hours from 09/01/23 through 09/07/23. During an interview on 10/11/23 at 1:15 P.M., the MDS Coordinator indicated she obtained information for UTIs in the last 30 days by looking at the Events and the physician's orders. If she had heard about an infection in the morning meeting, she would make sure it was put into an Event. Residents had to have an actual diagnosis in the last 30 days of a UTI, signs and symptoms, and lab findings. The Event was put in for Resident F's UTI, but she was not sure why it was not captured on the MDS assessment. Resident B's UTI should have been captured on the MDS assessment as well. She was not doing the MDS assessments at that time. They did not have a policy related to completing the MDS assessments. They followed the RAI (Resident Assessment Instrument) manual. This citation relates to Complaint IN00418465. 3.1-31(c)(1)			

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;			

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	(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines during toileting care for 1 of 5 residents reviewed for infection control. (Resident E) Findings include:	F 0880	It is the policy of this facility to ensure that proper infection control guidelines are followed, including during toileting care. 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	11/08/2023

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	During an observation on 10/11/23 at 10:30 A.M., Resident E was provided toileting care by CNA (Certified Nurse Aide) 2 and RN 3. Upon entering the resident's room, supplies were already placed on the over the bed table, including fresh towels, wash cloths, and a pan of water. The staff members washed their hands with soap and water, closed the doors and blinds, then pulled the privacy curtains. The resident requested the bed pan. The staff donned gloves, opened the resident's brief, placed the bed pan between the brief and the resident, and pulled the brief up to cover the front of the resident's peri area (vaginal area). They raised the head of the bed, provided privacy, placed the call light in reach, and left the room. The staff reentered the room, explained care to the resident, washed their hands, and donned clean gloves. They prepared a clean bag at the foot of the bed for soiled linens, removed the tape on the brief, and rolled the resident to her left side. The CNA held the resident on her left side while the RN provided care. The RN removed the bed pan, wiped feces off the resident's buttocks with the brief, then changed gloves. The RN wet a washcloth in the pan of clean water, cleaned feces off the buttocks, placed the washcloth in the plastic bag for soiled linens, removed the brief, and put it in the trash can. The resident was rolled to her back. Keeping the same gloves on, the RN picked up the bottle of body wash, squirted some into the wash pan of water, wet a washcloth in the pan, and cleaned the front of the resident's peri area (vaginal), wiping and turning the washcloth. They rolled the resident back to her left side and cleaned her rectal area with cloths dipped in the soapy water. The RN dumped the wash pan in the bathroom and refilled it with clean water. Keeping the same gloves on, the RN dipped a washcloth in the water, wiped the rectal area, dried the rectal area with a clean towel, then dried the front of the		All clinical staff have been in-serviced by the Infection Control nurse on Perineal Care on 10/20/2023. Skill validation was completed for CNA 2 and RN 3. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents in the facility have the potential to be affected. Perineal Care in-service and skill validation was completed by the Infection Control Nurse on 10-20-23. All residents who are incontinent have the potential to be affected. Any staff member who does not perform Perineal Care correctly will have disciplinary action up to and including termination. 3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur? All staff will be in-serviced by Relias course, overseen by the Infection Prevention and Clinical Education Coordinator Registered Nurse, on Infection prevention and control to be completed by 11/08/23. In addition to the above course, all nurses and CNA's will have courses on the basics of perineal care all to be completed by 11/08/2023. DNS/designee will round to ensure appropriate perineal care is provided.	

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	peri area with a clean towel, still wearing the same gloves. Both staff removed their gloves, washed their hands, donned clean gloves, assisted the resident with a pull-up brief, and repositioned the resident in their bed. The staff emptied the wash pan, cleaned the bed pan, gather the soiled supplies, used hand sanitizer, and left the room. During an interview on 10/11/23 at 1:49 P.M., CNA 2 indicated during pericare, after cleaning the rectal area, staff should change gloves, wash their hands, put on a clean pair of gloves, and look for rips, tears, or holes in the gloves before proceeding to other areas of the resident's body. The clinical record was reviewed on 10/11/23 at 11:18 A.M. An Admission MDS (Minimum Data Set) assessment, dated 08/29/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, fractures of the femur and right great toe. The resident required extensive assistance of two staff members for bed mobility and toileting. The current "Perineal Care" Procedure Steps policy, with a reviewed date of 03/2023, was provided by the DON (Director of Nursing) on 11/11/23 at 2:15 P.M. The policy indicated, in sequential steps, "...4. Perform hand hygiene...5. Don gloves...8. Assist resident to spread legs and lift knees, if possible...12. Separate labia and wash urethral area first...20. Change water in basin. With a clean washcloth, rinse area thoroughly in the same direction as with washing...21. Gently pat dry area in same direction as washing...22. Assist resident to turn onto side away...24. Clean anal area...25. Change water in basin. With a clean washcloth, rinse area thoroughly in the same direction as with washing...26. Gently pat area dry in same direction as when washing...27. Assist		4 How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur? The Infection Prevention RN and/or designee will observe and audit one peri-care procedure daily, Monday through Friday, for four weeks and then one peri-care procedure weekly for eight weeks then monthly for 3 months to ensure proper infection control and perineal care is performed per the policies and the care plan, beginning 10/16/2023. Results of these audits will also be brought to QAPI meeting monthly for further review and recommendations for 6 months. At the end of that time, if 100% compliance is reached, the committee may decide to stop the documented audits, if 100% compliance is not achieved an action plan will be developed. Date of compliance: 11/08/23	

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	resident to turn onto back...28. Doff gloves...29. Perform hand hygiene..." The current Infection Prevention and Control Program policy, with a revised date of 05/2023, was provided by the DON on 10/11/23 at 2:42 P.M. The policy indicated, "...The facility shall establish and maintain infection prevention and control program...designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections..." This citation relates to Complaint IN00418465. 3.1-18(b)			