

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/18/2025
NAME OF PROVIDER OR SUPPLIER Swiss Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W Main St Berne, IN 46711	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review the facility failed to ensure abuse allegations were reported in a timely manner for 3 of 5 residents reviewed (Resident B, Resident C and Resident D). Findings include: A report, dated 8/1/25, indicated Student Certified Nurse Aide (CNA) 7 indicated CNA 2 made inappropriate comments about Resident B while providing care to Resident B's genital area on 6/21/25 during 2nd shift. CNA 7 indicated she did not report the allegation to anyone until 8/1/25. An investigation file was provided by the Director of Nursing on 8/18/25 at 11:29 AM. The file included the following statements: CNA 3's statement, dated 8/1/25 at 2:16 PM, indicated he observed CNA 2 make inappropriate comments in front of Resident B, Resident C and Resident D. CNA 3 indicated he observed CNA 2 compare Resident B's genital sizes to Resident D's during pericare with Resident B. CNA 3 indicated he observed CNA 2 tell Resident C after getting him laid down she would come back and lay in bed with him and she could be the big spoon. The statement indicated he reported the incident to the nurse. CNA 9's statement, dated 8/1/25, at 2:25 PM, indicated she observed CNA 2 call Resident D sexy when she performed pericare. CNA 9 indicated she had also observed CNA 2 make statements about Resident B's genitals and size. CNA 9 indicated CNA 2 had made the comments in front of the nurse and the nurse was aware of the comments. Student CNA 7's statement, dated 8/1/25, untimed, indicated she heard CNA 2 make inappropriate comments during care with Resident B. Student CNA 7 indicated she overheard CNA 2 state after care was completed with Resident B she would return and lay with Resident B in his bed. Student CNA 7 indicated the statement occurred on 7/21/25 during second shift and CNA 7 reported the incident on 8/1/25 to the Assistant Director of Nursing (ADON). Student CNA 8's statement, dated 8/1/25, at 2:11 PM, indicated she overheard CNA 2 tell Resident B after Student CNA 7 and Student CNA 8 leave, CNA 2 would come back and lay with him in his bed. Student CNA 8 indicated she did not report the incident as CNA 2 made inappropriate comments all the time. Student CNA 8 also indicated CNA 2 made fun of other residents and comments had been reported the nurse. Student CNA 8 indicated the response from other staff indicated CNA 2 was just like that and then nothing was done about it. During an interview, on 8/18/25 at 1:06 PM, CNA 6 indicated she had never observed any inappropriate touching or comments towards residents by CNA 2 or any other staff but had overheard CNA 2 make comments about Resident B's genitals to other staff members. CNA 6 indicated abuse included physical harm, inappropriate comments/touching and verbal yelling. CNA 6 indicated when she observed abuse, she reported to the nurse. CNA 6 indicated when the nurse did not act immediately, she alerted the Director of Nursing (DON). During an interview, on 8/18/25 at 1:38 PM, CNA 3 indicated he had observed CNA 2 make inappropriate comments towards Resident B and Resident C. CNA 2 indicated he observed CNA 2 make comments about the male residents' genitals and size comparison. CNA 3 also indicated he overheard CNA 2 ask if she could come back later and lay with Resident C and she wanted to be the big spoon. CNA 3 indicated he reported this to the Qualified Medication Aide (QMA) on duty, but was unsure what her name was or if any follow up action was made. During an</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>interview with QMA 5, on 8/18/21 at 1:26 PM, she indicated abuse included name calling and directly/indirectly talking inappropriately about residents. QMA 5 indicated she overheard CNA 2 make inappropriate comments about residents, but nothing was reported to QMA 5. QMA 5 indicated when abuse allegations were observed or reported, she reported the allegations to the DON immediately. During an interview, on 8/18/25 at 11:58 AM, the ADON indicated she had received no reports CNA 2 until Student CNA 7 indicated CNA 2 had made inappropriate comments about residents. Student CNA 7 indicated she overheard CNA 2 tell Resident B she would come back to lay with him when Student CNA 7 and Student CNA 8 left during 2nd shift on 7/21/25. The ADON indicated the allegation was not brought to the attention of the ADON until 8/1/25. The ADON indicated the DON and ADON started an investigation. Staff interviews with nurses and CNAs were included. Based on the investigation, many CNAs reported CNA 2 made inappropriate comments about Resident B, Resident C and Resident D as well as other residents. The investigation indicated the CNAs told the nursing staff at times but were told CNA 2 was just like that. When the nurses were questioned, many of the nurses did not receive any reports of abuse allegations, inappropriate touching or comments. The ADON indicated when any allegation of abuse occurred the staff were to report to the nurse, ADON, DON and Administrator immediately. A policy, undated, titled abuse prevention, was provided by the Administrator on 8/18/25 at 2:39 PM. The policy indicated abuse included any oral, written and/or gestured language that willfully includes derogatory terms to the residents, family, or anyone within hearing distance; regardless of age, ability to comprehend or disability. The policy indicated charge nurses and nursing staff are responsible for monitoring any employee or resident at risk for abuse, including derogatory language, rough handling and communication disorders. The policy indicated any potential abuse allegation was reported to the Administrator immediately for investigation. This finding relates to Intake 2579139. 3.1-28(c)</p>		