

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 11, 12, 13, 14, & 15, 2016.</p> <p>Facility number: 000142 Provider number: 155237 AIM number: 100266940</p> <p>Census bed type: SNF/NF: 92 Total: 92</p> <p>Census payor type: Medicare: 11 Medicaid: 68 Other: 13 Total: 92</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on July 18, 2016.</p>	F 0000	<p>This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUEST A DESK REVIEW IN LIEU OF POSTSURVEY REVIEW on or after August 3rd.</p>	
F 0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES</p>			

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

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
Bldg. 00	<p>(INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to properly notify a resident's contact person of changes relating to a resident's care and change in room location for a resident who was severely impaired in their ability to make decisions. (Resident #55)</p>	F 0157	<p>F 157 Notify ofChanges The facility must immediately inform the resident: Consultwith the resident's physician; and if known, notify the resident's legalrepresentative. The facility must record and periodically update the addressand phone</p>	08/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Findings include:</p> <p>A clinical record review was completed on 7/13/16 at 9:37 a.m. Diagnoses included, but were not limited to dementia and schizophrenia.</p> <p>A Brief Interview for Mental Status completed in May of 2016, indicated Resident #55 scored 6 out of 15, indicating severe cognitive impairment.</p> <p>A careplan dated 4/16/15, last revised on 6/27/16, indicated Resident #55 experienced short and long term memory deficits with impaired decision making ability.</p> <p>The clinical record face sheet, indicated Resident #55's contact person was a case manager at a local company.</p> <p>On 7/13/16 at 9:10 a.m., an attempt was made to contact the case manager listed for Resident #55, but the contact person was unable to be reached. An employee at the local company, indicated the case manager for Resident #55 stopped overseeing the resident's case in 2014, upon discharge from the resident's previous facility.</p> <p>A review of Resident #55's clinical</p>		<p>number of the resident's legal representative or interested family member. What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? Resident #55. On 7/13/16 BVNH contacted Attorney Robert Thompson to begin the emergency guardian process. Attorney filed a petition and a court date has been set for August 3, 2016. On this date, BVNH will update guardian information on profile as needed. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficiency. License nurses will be in-service by Director of Nursing Services or designee by August 6th on proper reporting of information change as it relates to responsible party contacts. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Licensed nurses will be serviced by Director of Nursing Services or designee by August 3, 2016 on proper reporting of information change as it relates to responsible party contacts. Social</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>record, indicated the resident has had the following changes in which a contact person should have been notified:</p> <p>a. Physical Therapy order dated 1/28/16, indicated Resident #55 was to receive physical therapy 3 times per week.</p> <p>b. A Physician's order dated 1/29/16, indicated Resident #55's order for Risperdal Consta (medication used to treat schizophrenia) was discontinued.</p> <p>c. A Physician's order dated 4/6/16, indicated Resident #55 was to receive Saphris (medication used to treat schizophrenia) daily.</p> <p>d. A skin assessment dated 5/17/16, indicated Resident #55 had a linear laceration to coccyx area.</p> <p>e. An event dated 5/19/16, indicated Resident #55 changed rooms within the facility.</p> <p>f. An Occupation Therapy note dated 6/9/16, indicated, "...Message left...concerning therapy order...."</p> <p>Review of the clinical record, lacked documentation indicating a contact person for Resident #55 had been spoken to and properly notified regarding the</p>		<p>Services Director/ Designee, during resident careconference will ask for updates to contact information. Customer Care Reps will ask for updated contact informationwhen conducting monthly customer care calls.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place; and By what date the systematic changes will be complete? August 3, 2016 Contact Information QAPI tool will be utilized weekly x 4, Monthly x 5. Data will be submitted to QAPI for follow up. If 95% threshold is not achieved, an actionplan will be developed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>above changes.</p> <p>During an interview on 7/13/16 at 10:42 a.m., the Director of Nursing and Memory Care Coordinator indicated they were not aware the contact person listed for Resident #55 was invalid. The DON indicated the staff have left voicemail at the contact number listed on Resident #55's clinical record. The clinical record lacked documentation of the left messages having been received and/or responded to by a case manger/contact person.</p> <p>On 7/13/16 at 11:44 a.m., the Administrator indicated the facility contacted a lawyer this morning and an emergency guardian was to be obtained.</p> <p>On 7/14/16 at 9:38 a.m., the Director of Nursing (DON) and Memory Care Coordinator indicated the Social Worker would be responsible for maintaining contacts for residents.</p> <p>On 7/15/16 at 2:35 p.m., the DON indicated no policy was found regarding responsibility for maintaining resident's contact persons.</p> <p>3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(b)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0250 SS=D Bldg. 00	<p>3.1-5(c)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure the contact person who is to be notified for any changes with the resident or resident's care was current for a resident who was severely impaired in their ability to make decisions. (Resident #55)</p> <p>Findings include:</p> <p>A clinical record review was completed on 7/13/16 at 9:37 a.m. Diagnoses included, but were not limited to, dementia and schizophrenia.</p> <p>A Brief Interview for Mental Status completed in May of 2016, indicated Resident #55 scored 6 out of 15, indicating severe cognitive impairment.</p> <p>A careplan dated 4/16/15, last revised on 6/27/16, indicated Resident #55 experiences short and long term memory deficit with impaired decision making</p>	F 0250	<p>F250 Provision of Medically Related Social Services. The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident. What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? Resident #55. On 7/13/16 BVNH contacted Attorney Robert Thompson to begin the emergency guardian process. Attorney filed a petition and a court date has been set for August 3, 2016. On this date, BVNH will update guardian information on profile as needed. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by</p>	08/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>ability.</p> <p>A review of the clinical record, indicated Resident #55's contact person was a case manager at a local company.</p> <p>On 7/13/16 at 9:10 a.m., an attempt was made to contact the case manger listed for Resident #55, but the case manager was unable to be reached. An employee at the local company, indicated the contact person for Resident #55 stopped overseeing the resident's case in 2014, upon discharge from the resident's previous facility.</p> <p>During an interview on 7/13/16 at 10:42 a.m., the Director of Nursing and Memory Care Coordinator indicated they were not aware the contact person listed for Resident #55 was invalid.</p> <p>On 7/13/16 at 11:44 a.m., the Administrator indicated the facility contacted a lawyer this morning and an emergency guardian was to be obtained.</p> <p>On 7/14/16 at 9:38 a.m., the Director of Nursing (DON) and Memory Care Coordinator indicated the Social Worker would be responsible for maintaining contacts for residents.</p> <p>On 7/15/16 at 2:35 p.m., the DON</p>		<p>thealleged deficiency. License nurses will be in-service by Director of NursingServices or designee by August 3, 2016 on proper reporting of informationchange as it relates to responsible party contacts. What measures will beput into place or what systematic changes will be made to ensure that thedeficient practice does not recur? Licensed nurses will be in serviced by Director of NursingServices or designee by August 3, 2016 on proper reporting of informationchange as it relates to responsible party contacts. Social Services Director/ Designee, during resident careconference will ask for updates to contact information. Customer Care Reps will ask for updated contact informationwhen conducting monthly customer care calls. How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place; and By what date the systematic changes will be complete? August 3, 2016 Contact Information QAPI tool will be utilized weekly x 4, Monthly x 5. Data will be submitted to QAPI for follow up. If 95% threshold is not achieved, an actionplan will be developed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0278 SS=D Bldg. 00	<p>indicated no policy was found regarding responsibility or procedure for maintaining resident's contact persons.</p> <p>3.1-34(a)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure the Minimum</p>	F 0278	<u>F278</u> <u>AssessmentAccuracy/Coordina</u>	08/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Data Set (MDS) assessment accurately reflected the current status of a resident's ability to make decisions (Resident #53) for 1 of 35 residents reviewed for cognitive status and a resident without teeth (Resident #32) for 1 of 3 residents who met the criteria for review of oral/dental status.</p> <p>Findings include:</p> <p>1. The clinical record of Resident #53 was reviewed on 7/15/16 at 11:46 a.m. Diagnoses for the resident included, but were not limited to, dementia with delusions.</p> <p>A Social Service progress note, dated 4/20/16, indicated Resident #53, "...is rarely able to make herself understood and rarely able to understand others. [Resident]...is severely impaired with regard to decision-making..."</p> <p>A quarterly MDS assessment, dated 4/20/16, indicated Resident #53 was independent in her ability to make decisions. This MDS was signed by the SSD, verifying his assessment was accurate, and signed by a Registered Nurse, verifying the assessment was completed.</p> <p>On 7/11/16 at 3:34 p.m., an attempt was</p>		<p>tion/Certified The assessment must accurately reflect the resident's status. What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? All MDS Assessments for Resident #53 and Resident #32 have been corrected and retransmitted to CMS. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficiency. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? MDS assessments will be reviewed to insure that they accurately reflect the dental and cognitive status for each of the residents identified. This information will be documented on an MDS audit. Any MDS assessments found to be inaccurate will be modified and retransmitted to accurately reflect the resident's status. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and By what date the systematic changes will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>made to interview Resident #53. Her response to the screening question was garbled and nonsensical.</p> <p>In an interview on 7/13/16 at 9:10 a.m., the Social Service Director (SSD) indicated Resident #53 is, "definitely severely impaired in her ability to make decisions." The SSD indicated he had made an error on the quarterly MDS dated 4/20/16.</p> <p>2. The clinical record of Resident #32 was reviewed on 7/14/15 at 10:50 a.m. Diagnoses for the resident included, but were not limited to, dementia.</p> <p>A nursing admission assessment, dated 3/3/16, indicated Resident#32 was not edentulous.</p> <p>A dietary careplan, dated 3/3/16, indicated Resident #32, "...has no teeth or dentures..."</p> <p>An admission Minimum Data Set (MDS) assessment, dated 3/10/16, indicated Resident #32 was not edentulous and had no oral/dental problems. The assessment was signed by a Registered Nurse verifying completion.</p> <p>A Nutrition Risk Assessment, dated 3/10/16, indicated Resident #32 was</p>		complete? August 3, 2016 MDS Coding QAPI tool will be utilized by the MDS Coordinator/Designee weekly x 4, Monthly x 5. Data will be submitted to QAPI for follow up. If 95% threshold is not achieved, an action plan will be developed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>edentulous.</p> <p>A quarterly MDS, dated 6/1/16, indicated Resident #32 was not edentulous and had no oral/dental problems. It was signed by a Registered Nurse.</p> <p>An observation of Resident #32 on 7/12/16 at 3:23 p.m., indicated he was edentulous. (without any teeth)</p> <p>3.1-31(i)</p>			