

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2016
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NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/16/16</p> <p>Facility Number: 000142 Provider Number: 155237 AIM Number: 100266940</p> <p>At this Life Safety Code survey, Bethany Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. Building 0101 was surveyed using Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0101 was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the</p>	K 0000	<p>F000</p> <p>This provider respectfully requests that the 2567 PLAN OFCORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUEST A DESKREVIEW IN LIEU OF POSTSURVEY REVIEW on or after August 30th.</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.

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K 0025 SS=E Bldg. 01	<p>corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 85 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except for one detached storage shed.</p> <p>Quality Review completed on 08/19/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of</p>	K 0025	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>· On 8/23/2016, the Maintenance Director filled the 2 inch diameter for ten cables with a fire stop caulking smoke barrier above the suspended ceiling at the corridor door set by the Salon.</p>	08/23/2016

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	<p>maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 40 residents, staff and visitors in the vicinity of the smoke barrier door set by the Salon.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Floor Technician during a tour of the facility from 10:50 a.m. to 12:25 p.m. on 08/16/16, a two inch in diameter open ended conduit for the passage of ten cables was noted in the smoke barrier wall above the suspended ceiling at the corridor door set by the Salon which was not firestopped. Based on interview at the time of observation, the Executive Director acknowledged the hole in the aforementioned smoke barrier wall did not ensure the smoke barrier wall was protected to maintain the smoke resistance of the smoke barrier.</p> <p>3.1-19(b)</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>· This deficient practice could affect residents, staff and visitors in the vicinity of the smoke barrier door set by the Salon.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>· Maintenance Supervisor will ensure that required smoke barrier walls are compliant with code. Systems are continuously maintained in reliable operating condition and are inspected periodically then verified by the Executive Director.</p> <p>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?</p> <p>Maintenance Director will inspect each Fire Barrier quarterly and update as needed. Maintenance will track Quarterly with Fire Barrier Maintenance checklist Tracking Tool to ensure barriers are in compliance. Maintenance Director will review with ED monthly during Safety Meeting. If 100% threshold is not achieved, an action plan will be</p>	

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K 0052 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,</p> <p>1. Based on record review and interview, the facility failed to document annual functional testing of all fire alarm system initiating devices. NFPA 72, 7-3.2 refers to fire alarm component testing frequencies in Table 7-3.2 which requires an annual functional test of all fire alarm system initiating devices. Section 7-5.2 requires a permanent record of all inspections, testing and maintenance shall be provided that includes information requested in Figure 7-5.2.2. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Vanguard Alarm Services "Facility Equipment Inspection" documentation dated 06/30/15, 10/29/15 and 01/28/16 with the Executive Director from 8:40 a.m. to 10:50 a.m. on 08/16/16, documentation of functional</p>	K 0052	<p>developed</p> <p><u>K052NFPA 101 Life Safety Code Standard</u> <u>Afire alarm system required for life safety is installed, tested and maintainedin accordance with NFPA 70 National Electrical Code and NFPA 72. Afire alarm system required for life safety is installed, tested and maintainedin accordance with NFPA 70 National Electrical Code and NFPA 72.Sensitivitytesting shall be checked within 1 year after installation and every alternatyear thereafter.</u></p> <p>- .Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice? ·Contractor visited and building receiveddocumentation of all fire alarm systems initiating on August 22, 2016. Alldevices passed. ·Contractor visited and the</p>	08/22/2016

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	<p>testing of all fire alarm system initiating devices within the most recent twelve month period was not available for review. Vanguard Alarm Services 10/29/15 documentation stated 16 of 103 initiating devices were tested and Vanguard's 01/28/16 documentation stated 10 of 103 initiating devices were tested. Based on interview at the time of record review, the Executive Director stated additional documentation of fire alarm system initiating device testing within the most recent twelve month period was not available for review and acknowledged documentation of annual functional testing of all fire alarm system initiating devices within the most recent twelve month period was not available for review.</p> <p>3.1-19(a)</p> <p>2. Based on record review and interview, the facility failed to ensure all smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity</p>		<p>buildingreceived documentation of all Smoke Detector Sensitivity testing on August 22,2016. All devices passed.</p> <p>Howwill you identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·Residents currently living in the facility, visitors and staff have the potential to be affected by this alleged deficient practice. <p>·What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · Maintenance Supervisor will ensure annual initiationtesting on all fire alarm systems is conducted annually by contractor thenverified by the Executive Director that testhave been completed. · MaintenanceSupervisor will ensure sensitivity testingon all smoke detector systems isconducted every two years by contractor then verified by the Executive Directorthat test have beencompleted. <p>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?</p> <p>MaintenanceDirector will maintain the Vendor Inspection Checklist</p>	

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	<p>range (or 4 percent obscuration light gray smoke, if not marked); the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors.</p>		<p>to verify all Quarterly, Semi Annual, Annul, Every Two Years and Every Five Years Inspections are completed. Maintenance Director will review this checklist with Executive Director monthly during safety meeting.</p> <p>-</p>	

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K 0064 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on record review with the Executive Director from 8:40 a.m. to 10:50 a.m. on 08/16/16, documentation of smoke detector sensitivity testing within the most recent two year period was not available for review. Based on interview at the time of record review, the Executive Director acknowledged sensitivity testing documentation for all facility fire alarm system smoke detectors within the most recent two year period was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>Based on observation and interview, the facility failed to document inspection of 1 of 15 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure</p>	K 0064	<p><u>K 064 Life Safety CodeStandard</u> <u>Portablefire extinguishers shall be installed, inspected and maintained in all health care occupancies inaccordance with 9.7.4.1, NFPA. The portable fire extinguisher in the 200 hallMechanical Room inspection tag indicated inspection completed March, 2016.</u></p> <p>- Whatcorrective action(s) will be</p>	08/22/2016

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	<p>the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 22 residents, staff and visitors in the vicinity of the 200 Hall Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Floor Technician during a tour of the facility from 10:50 a.m. to 12:25 p.m. on 08/16/16, the portable fire extinguisher in the 200 Hall Mechanical Room had an inspection tag affixed to the extinguisher which indicated an annual inspection was conducted in March 2016. However, a monthly inspection was not documented for the three month period of May 2016 through July 2016. Based on interview at the time of observation, the Executive Director stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguisher was not documented for the three month period of May 2016 through July 2016.</p>		<p>accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> The building inspected fire extinguisher on the 200 hall and dated August 22, 2016. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> Residents currently living in the facility, visitors and staff have the potential to be affected by this alleged deficient practice. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Maintenance Supervisor will follow the "Monthly Fire Extinguisher" checklist to ensure that required fire extinguishers are inspected and dated each month. <p>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?</p> <p>Maintenance Supervisor will follow the "Monthly Fire Extinguisher" checklist to ensure that required fire extinguishers are inspected and dated each month. Maintenance Director will review with ED monthly during Safety Meeting. If 100% threshold is not</p>	

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K 0072 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 6 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Floor Technician during a tour of the facility from 10:50 a.m. to 12:25 p.m. on 08/16/16, the exit door to the outside of the facility in the Main Dining Room and by Room 414 were each marked as a facility exit but were also each marked with a no exit sign. Based on interview at the time of observation, the Executive Director acknowledged each of the aforementioned two exits were facility</p>	K 0072	<p>achieved, an action plan will be developed.</p> <p>-</p> <p><u>K072 Life Safe CodeStatus</u></p> <p>-</p> <p><u>Means of egress shall be continuously maintained free of all obstructions.</u></p> <p>The facility failed to ensure 2 of 6 means of egresswas continuously maintained and free of obstruction. The exit doors to outside of the facility inthe main dining room and by room 414 were each marked as a facility exit butwere also marked as not an exit.</p> <p>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?</p> <p>On 8/23/2016,the Maintenance Director removed the “not an exit” sign in the main dining roomand by room 414.</p> <p>Howwill you identify other residents having the potential</p>	08/23/2016

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K 0130 SS=E Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation, interview; the facility failed to ensure the care and maintenance of 2 of 2 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required exits and should not be marked as not an exit. 3.1-19(b)	K 0130	<p>to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> Residents currently living in the facility, visitors and staff have the potential to be affected by this alleged deficient practice. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Maintenance Supervisor will not place "not an exit sign" at any of the doors leading out of the facility. <p>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?</p> <p>Maintenance Director and Executive Director will walk through the building monthly and visually confirm the corrective action is maintained.</p> <p><u>K130 NFPA 101 Life Safety Code Standard Miscellaneous NFPA 80, 1999 Edition, the standard for fire door and fire windows, section 15-2.4.3 requires all horizontal or vertical sliding and rolling</u></p>	08/22/2016

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	<p>for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 30 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on record review with the Executive Director from 8:40 a.m. to 10:50 a.m. on 08/16/16, documentation of facility rolling fire door inspection within the most recent twelve month period was not available for review. Based on observations with the Executive Director and the Floor Technician during a tour of the facility from 10:50 a.m. to 12:25 p.m. on 08/16/16, the facility has two rolling fire doors protecting the two openings from the kitchen to the Main Dining Room and each rolling door had</p>		<p><u>fire doors to be inspected and tested annually to check for proper operation and closing.</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Contractor inspection and received documentation of two rolling doors on August 22, 2016. Both doors devices passed.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · Residents currently living in the facility, visitors and staff have the potential to be affected by this alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Maintenance Supervisor will ensure annual inspection and testing on two rolling doors fire alarm systems is conducted annually by contractor then verified by the Executive Director that tests have been completed.</p> <p>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?</p>	

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K 0147 SS=E Bldg. 01	<p>an affixed annual maintenance inspection sticker from Vanguard Alarm Services indicating the most recent rolling door inspection was April 2015. The Main Dining Room is open to the corridor. Based on interview on at the time of the observations, the Executive Director acknowledged documentation of an annual inspection or test to check for proper operation and full closure for each of two rolling fire doors within the most recent twelve month period was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 3 of 3 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all</p>	K 0147	<p>MaintenanceDirector will maintain the Vendor Inspection Checklist to verify all Quarterly, Semi Annual, Annul, Every Two Years and Every Five Years Inspections arecompleted. Maintenance Director willreview this checklist with Executive Director monthly during safety meeting.</p> <p><u>K 147 101 Life SafeCode Status</u></p> <p>- <u>The facility failed toensure 3 of 3 extension cords including power strips were not used as a substitute for fixed wiring.</u></p> <p>- A refrigerator was plugged into a powerstrip in Medication room at skilled nurse's station. - Two Refrigerators were were plugged intoa power strip on the ICF nurses station. - Telephone charger was</p>	08/24/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2016
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NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
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	<p>applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 50 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Floor Technician during a tour of the facility from 10:50 a.m. to 12:25 p.m. on 08/16/16, the following was noted:</p> <p>a. a refrigerator was plugged into a power strip in the Medication Room at the skilled nurse's station.</p> <p>b. two refrigerators were plugged into a power strip in the Medication Room at</p>		<p>plugged into a power strip on the floor underneath a resident bed.</p> <p>.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · On 8/24/2016, the Maintenance will install electric reciprocal in Medication room at skilled nurse's station. · On 8/24/2016, the Maintenance Director will install an electrical reciprocal in medication room at ICF station.. · On 8/16/2016, the Executive Director immediately disconnected the telephone charger from power strip in room 505. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · Residents currently living in the facility, visitors and staff have the potential to be affected by this alleged deficient practice. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · On 8/23/2016, the Maintenance Director to in-service staff on importance of phone chargers not being connected to a power strips. · Maintenance Director 	

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K 0000 Bldg. 02	<p>the ICF nurse's station.</p> <p>c. a telephone charger was plugged into a power strip on the floor underneath the resident bed nearest the corridor door in Room 505.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring in the aforementioned Medication Rooms and in the patient care vicinity in Room 505.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/16/16</p> <p>Facility Number: 000142 Provider Number: 155237 AIM Number: 100266940</p> <p>At this Life Safety Code survey, Bethany</p>	K 0000	<p>installelectrical reciprocal and removed power strip in Medication room ICF.</p> <p>·MaintenanceDirector installed electrical reciprocal and removed power strip in Medicationroom ICF.</p> <p>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?</p> <p>Maintenance Directorand Executive Director will walk through the building monthly and visuallyconfirm the corrective action is maintained.</p> <p>F000 This provider respectfully requests that the 2567 PLAN OFCORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUEST A DESKREVIEW IN LIEU OF POSTSURVEY REVIEW on or after August 30th.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2016
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NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
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	<p>Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. Building 0202 was surveyed using Chapter 18, New Health Care Occupancies.</p> <p>Building 0202 was constructed in 2012, was determined to be of Type V (111) construction, was fully sprinklered and consisted of the Therapy Room. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 85 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except for one detached storage shed.</p> <p>Quality Review completed on 08/19/16 - DA</p>			