

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2023
NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3530 S SHELBY ST, INDIANAPOLIS, , 46227			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00397622 completed on January 18, 2023. This visit was in conjunction with the PSR to the Investigation of Complaint IN00400483 completed February 13, 2023. Complaint IN00397622 - Corrected. Complaint IN00400483 - Corrected. Survey date: March 17, 2023 Facility number: 001121 Residential Census: 75 Bethany Village Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00397622. Quality review completed March 20, 2023.	R 0000			

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FORM APPROVED

OMB NO. 0938-0391

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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