STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHANY VILLAGE ASSISTED LIVING	3530 S SHELBY ST INDIANAPOLIS, IN 46227

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: February 11 and 12, 2025 Facility number: 001121 Residential Census: 68 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 14, 2025.	R 0000		
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency Based on observation, record review, and interview, the facility failed to report an unusual occurrence to Indiana Department of Health (IDOH). A broken water pipe and associated water damage resulted in the displacement of 5 of 68 residents who had to be relocated to other apartments. Finding includes: On 2/11/25 at 8:30 a.m., during the initial facility tour, the following was observed on the 100 Hall: - Plastic was taped to the floor the length of the hallway - Plastic was taped over multiple doors to prevent entry into the room. - Plastic was taped over the lower 12" of the wall. During an interview on 2/11/25 at 10:45 a.m., the	R 0090	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Review of the Indiana Department of Health Incident Reporting Policy was completed by Executive Director by 2/27/25 for reporting unusual occurrences in coordination with community policy. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All Residents have the potential to be affected. No Resident was adversely affected. All staff will participate in a review and education of the Indiana Department of Health Incident	05/26/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gary Griffin	Executive Director	02/28/2025

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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	Corporate Nurse indicated a pipe had broken and flooded the area on the main floor on the 100 Hall. Five residents had to be moved to a different room due to water damage. The Corporate Nurse indicated the incident occurred last month. The Corporate Nurse was unaware if the incident had been reported to the IDOH. During an interview on 2/11/25 at 12:33 p.m., the Maintenance Director indicated the pipe broke January 17, 2025. On 2/12/25 at 9:00 a.m., the Clinical Nurse Specialist provided a document [restoration company estimate for repairs], dated 2/1/25. The document indicated the facility had "water damage". The damage included, but was not limited to, main level walls, ceiling, and flooring. At that time, the Clinical Nurse Specialist indicated the unusual occurrence should have been reported to IDOH. On 2/12/25 at 10:11 a.m., Resident 29 indicated there was water everywhere and it was several inches deep. On 2/12/25 at 11:33 a.m., the facility lacked documentation that supported the unusual incident report was submitted to IDOH regarding a broken water pipe, flooding, structural damage, and the displacement of 5 residents. On 2/12/25 at 9:00 a.m., the Clinical Nurse Specialist provided a policy titled Unusual Occurrences for Residents, dated December 2017, and indicated it was the current policy being used by the facility. A review of the policy indicated "...All reportable incidents which occur against a resident will be reported to the ISDH [IDOH]. Reportable incidents: is defined as any		Reporting Policy for unusual occurrences and reporting by March 9, 2025. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All staff will participate in a review and education of the Indiana Department of Health Incident Reporting Policy for unusual occurrences and reporting by March 9, 2025. 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 systemic changes will be completed. A monitoring tool will be completed 3 times weekly x 4 weeks, then once weekly x 8 week questioning staff of the company policy for unusual occurrences and reporting . If 100% threshold is not met, then disciplinary action and new action plan will be completed. Monitoring tool will be completed by the Executive Director/designee. This tool will be completed by May 26, 2025.	

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	occurrence not consistent with the routine operation of the nursing facility, which may have caused or may have the potential for causing injury to residents, visitors, or loss or damage of resident property..."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 3 of 3 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Cook 2) Findings include: 1. During the initial kitchen tour with the Dietary Manager, on 2/11/25 from 10:00 a.m. to 10:15 a.m., the following was observed: - Cook 2 was observed walking through out the kitchen preparation area. Cook 2 was observed wearing a ball cap that covered the crown of his head to the top of his ears. Cook 2's hair from the base of the ball cap to the neckline was observed to be approximately one-half inch in length. The hair was observed to not be covered. Cook 2 was observed wearing a beard guard that covered part of his jaw and mouth area. Cook 2 was observed to have facial hair, approximately one-quarter inch in length, located in front of the ears and along the jaw line area. The facial hair was observed to not be covered. 2. During a follow-up kitchen observation on 2/11/25 from 11:00 a.m. to 11:10 a.m., the following was observed:	R 0273	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Cook 2 was educated on 2-12-25 by the Culinary Director on culinary personal hygiene policy to include hair restraint must cover all hair How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All Residents have the potential to be affected. No Resident was adversely affected. Culinary staff was re-educated by the Culinary Director on 2-12-25 concerning culinary personal hygiene policy, including but not limited to ensuring all hair/facial hair is covered What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Culinary staff was re-educated by the Culinary Director on 2-5-25 concerning culinary personal hygiene policy,	05/26/2025

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	- Cook 2 was observed at the steam-table taking the starting temperatures of the noon meal and plating the noon meal. Cook 2 was observed wearing a ball cap that covered the crown of his head to the top of his ears. Cook 2's hair from the base of the ball cap to the neckline was observed to be approximately one-half inch in length. The hair was observed to not be covered. Cook 2 was observed wearing a beard guard that covered part of his jaw and mouth area. Cook 2 was observed to have facial hair, approximately one-quarter inch in length, located in front of the ears and along the jaw line area. The facial hair was observed to not be covered. During an interview on 2/11/25 at 11:15 a.m., the Dietary Manager indicated all staff hair was to be covered when in the kitchen. 3. During a follow-up kitchen observation on 2/11/25 from 1:15 p.m. to 1:20 p.m., the following was observed: -Cook 2 was observed at the steam-table taking the ending temperatures of the noon meal. Cook 2 was observed wearing a ball cap that covered the crown of his head to the top of his ears. Cook 2's hair from the base of the ball cap to the neckline was observed to be approximately one-half inch in length. The hair was observed to not be covered. Cook 2 was observed wearing a beard guard that covered part of his jaw and mouth area. Cook 2 was observed to have facial hair, approximately one-quarter inch in length, located in front of the ears and along the jaw line area. The facial hair was observed to not be covered. On 2/11/25 at 1:30 p.m., the Dietary Manager provided a copy of the Culinary Personal Hygiene policy dated, May 2024, and indicated it was the		including but not limited to ensuring all hair/facial hair is covered. 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 systemic changes will be completed. Culinary personal hygiene monitoring tool will be completed 3 times weekly x 4 weeks, then once weekly x 8 week. If 100% threshold is not met, then disciplinary action and new action plan will be completed. Monitoring tool will be completed by Culinary Manager or Executive Director/designee. This tool will be completed by May 26, 2025.	

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	current policy in use by the facility. A review of the document indicated, "...All employees working in the culinary department must wear a clean hair restraint which effectively covers all hair. A ball cap...may be worn over a proper hair restraint. Culinary employees with facial hair must also wear a beard restraint..." On 2/12/25 at 2:00 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints...that are designed and worn to effectively keep their hair from contacting...exposed food..."			