STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 00 B. WING	09/10/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00442889 and IN00441467. Complaint IN00442889 - No deficiencies related to the allegations are cited. Complaint IN00441467 - No deficiencies related to the allegations are cited. Survey dates: September 4, 5, 6, 9, and 10, 2024 Facility number: 000142 Provider number: 155237 AIM number: 100266940 Census Bed Type: SNF/NF: 89 Total: 89 Census Payor Type: Medicaid: 73 Other: 16 Total: 89 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 13, 2024.	F 0000	F000	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on observation, interview, and record	F 0558	**F558 Reasonable Accommodations**	09/30/2024

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

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	review, the facility failed to ensure reasonable accommodation of needs for 1 of 8 residents observed. A call light was not within reach. (Resident 86) Finding includes: On 9/10/24 at 1:45 p.m., observed Resident 86 in bed. Resident 86's call light was hanging over the bed and was on the floor next to the residents bed, out of the reach of the reach of the resident. During an interview at that time, the Assistant Director of Nursing (ADON) indicated the call light should have been within the reach of the resident. On 9/10/24 at 11:52 a.m., the DON provided a policy titled Resident Bill of Rights, dated 12/2017, and indicated it was the current policy being used by the facility. A review of the policy indicated, "...(b. the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the community..." 3.1-3(v)(1)		**Needs/Preferences** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Call light is within reach for Resident 86 **How will you 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 by the alleged deficient practice. Observational rounds were completed by Care Companions x1 to ensure that call lights are in reach for all residents. All staff will be in-serviced on call lights in reach for residents by ED/designee on or before 9/30/24 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff will be in-serviced on call lights in reach for residents by ED/designee on or before 9/30/24 Observational rounds will be completed by Care Companions daily to ensure that call lights are in reach for all residents. **How the corrective action (s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance program will be put into place? ED/designee will be responsible for the completion of the Call Light audit tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to ensure all staff is compliant with ensuring call lights are in place and within reach until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure that written notification was provided to the Office of the State Long-Term Care Ombudsman for 1 of 4 residents reviewed for written transfer and discharge notification. (Resident 39) Finding includes: On 9/5/24 at 1:05 p.m., Resident 39's clinical record was reviewed. The diagnoses include, but were not limited to, delusional disorder, severe dementia with agitation, and mood disturbance. The Quarterly Minimum Data Set (MDS)	F 0623	**F623 Notice Requirements Before Transfer/Discharge** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Ombudsman notification of transfers was completed for Resident 39. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents that transfer from the facility have the potential	09/30/2024

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	assessment, dated 8/1/24, indicated Resident 39 was severely cognitively impaired. 1. The ASC (American Senior Communities) Hospital ER (Emergency Room/Department) Transfer Form, dated 3/18/24, indicated Resident 39 was transferred to the hospital Emergency Department on 3/18/24 at 8:06 a.m. The transfer was a facility-initiated transfer. 2. The ASC Hospital ER Transfer Form, dated 3/19/24, indicated Resident 39 was transferred to a psychiatric hospital on 3/19/24 at 2:30 p.m. The transfer was a facility-initiated transfer. 3. The ASC Hospital ER Transfer Form, dated 4/27/24, indicated Resident 39 was transferred to a psychiatric hospital on 4/27/24 at 7:40 p.m. The transfer was a facility-initiated transfer. 4. The ASC Hospital ER Transfer Form, dated 5/22/24, indicated Resident 39 was transferred to the ER and then transferred to a psychiatric facility on 5/22/24 at 2:30 p.m. The transfer was a facility-initiated transfer. The clinical record lacked documentation that the Office of the State Long-Term Care Ombudsman was notified, in writing, that Resident 39 had been transferred to another facility in March 2024, April 2024, and May 2024. During an interview on 9/10/24 at 12:31 p.m., the Social Service Director indicated Resident 39's transfer to the Emergency Department and to a psychiatric facility was a facility-initiated transfer. The Office of the State Long-Term Care Ombudsman had not been notified of Resident 39's facility-initiated transfers to another facility in March 2024, April 2024, and May 2024.		to be affected by the alleged deficient practice. An audit will be completed on all residents of the facility to ensure the Office of the state long term Care Ombudsman is notified on every facility-initiated transfers. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** An in-service will be completed by ED/designee for Social Services Director to include notification of Ombudsman of any resident transferring from facility by 9/30/24. Monthly reminders have been set on the social services calendar to send notifications to the Ombudsman. Monthly report will be reviewed by IDT. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/designee will be responsible for the completion of the ----------Emergency Transfer Notifications QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. -The results of these audits will be reviewed by the QAPI committee overseen by	

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	During an interview on 9/10/24 at 1:00 p.m., the Administrator indicated the facility lacked a specific policy regarding the Office of the State Long-Term Care Ombudsman notification of a resident's facility-initiated transfer to another facility. 3.1-12(a)(6)(A)		the ED. If a threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) assessment was completed for 2 of 4 residents reviewed for accuracy of MDS assessments. Falls were not coded correctly. (Resident 35, Resident 92) Findings include: 1. The clinical record of Resident 35 was reviewed on 9/5/24 at 1:45 p.m. The diagnoses included, but were not limited to, Parkinson's disease, unsteadiness on feet, repeated falls, generalized muscle weakness, syncope and collapse, and difficulty in walking not. A Fall Event, dated 7/9/24, indicated an unwitnessed fall. Resident 35 had left shoulder pain that required x-rays to rule out fracture. A Quarterly MDS assessment, dated 8/7/24, indicated Resident 35 had not had any falls since their prior MDS assessment, a Quarterly MDS assessment, dated for 5/10/24. During an interview on 9/9/24 at 10:50 a.m., the MDS Coordinator indicated the MDS assessment,	F 0641	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** MDS for Resident 35 and 92 for falls has been corrected. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with falls have potential to be affected by the alleged deficient practice The MDS coordinator will be in-serviced by the ED/designee on accurate coding on the MDS assessment for falls 1 x audit of all residents who have experienced a fall has been completed to ensure falls are coded accurately. Any inaccurate coding has been modified and	09/30/2024

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	dated 8/7/24, should have indicated Resident 35 had experienced falls. 2. The clinical record of Resident 92 was reviewed on 9/5/24 at 1:03 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, unspecified dementia, generalized muscle weakness, and age-related physical debility. A Fall Event, dated 7/7/24, indicated a witnessed fall where Resident 92 stood and fell close to a nursing station. A Fall Event, dated 7/13/24, indicated a witnessed fall where Resident 92 stood from her chair and fell. A Fall Event, dated 7/21/24, indicated an unwitnessed fall where Resident 92 was found by staff sitting on the floor of their room. A Significant Change MDS assessment, dated 7/22/24, indicated Resident 92 had not had any falls since their prior MDS assessment, a Significant Change assessment, dated for 5/19/24. During an interview on 9/9/24 at 9:46 a.m., the MDS Coordinator indicated the MDS assessment, dated 7/22/24, should have indicated Resident 92 had experienced falls. During an interview on 9/9/24 at 10:50 a.m., the MDS Coordinator indicated the facility followed RAI (Resident Assessment Instrument) guidelines for MDS assessments. 3.1-31(d)		resubmitted. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The MDS coordinator will be in-serviced by the ED/designee on accurate coding on the MDS assessment for falls ·Once weekly the DNS/designee will re-review all MDS assessments for the week identifying any residents with falls to ensure accurate coding. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** MDS/designee will be responsible for the completion of the MDS Accuracy QA tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to ensure all wound care practices in place until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not	

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			achieved an action plan will be developed to ensure compliance.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, interview, and record review, the facility failed to provide services to a resident with an ulcer on her right heel for 1 of 3 residents reviewed for pressure ulcers. (Resident 86) Finding includes: On 9/6/24 at 10:15 a.m., observed Resident 86's right heel to have an uncovered wound. The area was not wrapped with gauze (a protective covering). On 9/9/24 at 9:33 a.m., observed Resident 86's right heel. The wound on the right heel was observed to be uncovered. On 9/9/24 at 11:22 a.m., observed the wound on Resident 86's right heel to not be wrapped in gauze. On 9/10/24 at 10:30 a.m., the clinical record for Resident 86 was reviewed. The diagnosis, included but was not limited to, type II Diabetes Mellitus. A Quarterly Braden Score (a risk assessment tool that predicts the likelihood of developing pressure ulcers), dated 8/15/24 indicated Resident 86 had a very high risk for pressure ulcers. A Physicians Order, dated 8/27/24, indicated cleanse right heel with normal saline, pat dry, apply collagen to wound bed, cover with board	F 0686	**F 686 Treatment Services to Prevent/Heal Pressure Ulcer Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident 86 is receiving wound care treatment per facility policy. **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 with risk of skin impairment have the potential to be affected by the alleged deficient practice. Nursing staff to be in-serviced on wound care treatments per policy on or before 9/30/24. Any resident with current wounds/pressure areas were assessed x1 to ensure current treatments were in place per MD order. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	09/30/2024

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	gauze every three days. During an interview on 9/9/24 at 11:25 a.m., the Assistant Director of Nursing indicated the wound on Resident 86's heel should have been wrapped and was unsure why it was not wrapped during the observations. On 9/8/24 at 3:45 p.m., the Executive Director provided a policy titled Skin Management Program, dated 5/2022, and indicated it was the current policy being used by the facility. A review of the policy indicated "Purpose: To promote the prevention of pressure ulcers/injury development; promote the healing of existing pressure ulcers and prevent development of additional pressure ulcer injury. ...4. preventative measures and treatments will be implemented as appropriate." 3.1-40(a)(2)		**practice does not recur?** Nursing staff to be in-serviced on wound care treatments per policy on or before 9/30/24. Observational rounds will be completed by DNS/designee daily to ensure wound care treatments are in place per order **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DNS/designee will be responsible for the completion of the Wound Dressing Audit QA tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to ensure all wound care practices in place until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure the facility was free from accident hazards for 1 of 1 observation, potentially affecting 36 of 56 self-mobile residents residing in the facility. A rubber hose used for	F 0689	Bethany Village is respectfully requesting face to face IDR. **What corrective action(s) will be accomplished for those residents found to have**	09/30/2024

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	fish tank maintenance was located on the floor in the middle of a walkway area that was used by the residents. (500 hall) Finding includes: During an observation, on 9/6/24 from 9:00 a.m. to 9:13 a.m., the following was observed on the 500-hall floor space between the resident pantry and the resident lounge area: - A dark colored rubber hose, approximately one inch in diameter and approximately 25 feet in length, was observed in the middle of the walkway that ran from the resident pantry room (on the left side of the hall) to the resident lounge (on the right side of the hall) of the 500-hall. - Approximately ten feet from the lounge area, the dark colored rubber hose was observed to be curled onto itself which raised the hose approximately two inches from the floor. - Approximately eight feet from the lounge area, the dark colored rubber hose was raised above the floor approximately three inches from the floor. - Multiple residents were observed watching television in the resident lounge. - No staff were visible in the area where the dark colored rubber hose was located. - No caution signs were visible in the hallway near where the dark colored rubber hose was located. On 9/6/24 at 9:14 a.m., LPN 2 was observed walking from the lounge area toward the nurse's station located across from the resident pantry room. During an interview at that time, LPN 2		**affected by the deficient practice?** No residents were affected by the alleged deficient practice Upon notification, caution signs were put in place to ensure residents were safe. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** ·All self-mobile residents have the potential to be affected by the alleged deficient practice. All staff in-service to be completed by the ED/designee on or before 9/30/24 regarding facility to be free of trip hazards **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All staff in-service to be completed by the ED/designee on or before 9/30/24 regarding facility to be free of trip hazards Observational rounds will be completed by the ED/designee daily to ensure facility is free from trip hazards **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	indicated she was unsure if any caution signs should have been placed near the rubber hose to alert residents of a potential trip hazard. During an interview on 9/6/24 at 9:50 a.m., the Administrator indicated the rubber hose should not have been placed in the middle of the walkway on the 500-hall. The hallway was to be kept clear of any potential tripping hazards. Caution signs should have been in place to alert residents of a potential tripping hazard. On 9/6/24 at 1:44 p.m., the Director of Nursing Services provided a document that indicated there were 36 of 56 self-mobile (ability to move independently without staff assistance) residents who had access to the 500-hall. On 9/6/24 at 2:16 p.m. the Administrator provided a copy of the American Senior Communities General Health and Safety Policies, dated 12/2023, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...all recognized safety and health hazards shall be eliminated or controlled as quickly as possible...must be kept free and clean of....extraneous materials that could create a health hazard or cause an accident..." 3.1-45(a)(1)		IDT will be responsible for the completion Quality Control Environmental Checklist weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to ensure all area of building are free of accidents until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, record review, and interview, the facility failed to ensure a treatment cart was locked and secured for 1 of 1 random observations. (Memory Care Treatment Cart) Findings include:	F 0761	**F761 Label/Storage of medications** **What corrective actions will be accomplished for those residents found to have been**	09/30/2024

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	On 9/6/24 from 9:00 a.m. to 9:15 a.m., during medication administration pass observation, on the memory care unit, observed an unlocked treatment cart with no staff present in the area. Multiple residents were observed wandering around the unit. The treatment cart was easily opened. Inside the unlocked cart, the following medicated treatments, included but were not limited to: - Two tubes containing 30 grams of Nystatin Topical Cream (a medicated cream was used to treat fungal or yeast infections on your skin). The tube of medicated cream indicated "...keep out of reach...". - One tube containing one ounce of vagisil cream (anti-itch medication). The label on the tube of medicated cream indicated "...keep out of reach...". - One fourteen ounce jar of Aquaphor healing ointment. The label on the ointment indicated "...keep out of reach...". During an interview on 9/6/24 at 9:10 a.m., LPN 3 indicated the treatment cart should have been locked. During an interview on 9/6/24 at 9:39 a.m., the Executive Director indicated the treatment cart should have been locked. On 9/6/24 at 1:44 p.m., the DON provided a document that indicated there were 20 of 25 cognitively impaired self-mobile residents residing on the Memory Care Unit. On 9/6/24 at 9:52 a.m., the Director of Nursing provided a policy titled Storage and Expiration		**affected by the deficient practice?** Treatment cart on memory care is locked when not in use **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. A 1x audit will be completed by DNS/designee to ensure all medication and treatment carts are locked when not in use. An in-service will be completed by DNS/designee on or before 9/30/24 with all licensed nurses on medication/treatment carts to be locked at all times when not in use **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** An in-service will be completed by DNS/designee on or before 9/30/24 with all licensed nurses on medication/treatment carts to be locked at all times when not in use Observational rounds will be completed daily by nurse managers/designee to ensure all medication and treatment carts	

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	Dating of Medications and Biologicals, dated 8/1/24, a review of the policy indicated "...5. Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors." 3.1-25(m)		are locked when not in use. Any concerns will be addressed immediately. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DNS/designee will be responsible for the completion of the Medication Storage Review audit tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to ensure all the carts are locked when not in use until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, record review, and interview, the facility failed to ensure a homelike atmosphere for 1 of 8 rooms observed for a homelike setting. Drywall was missing. (Room 111, Resident 86) Finding included: During a tour of the facility on 9/4/24 at 10:30 a.m.,	F 0921	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Hole in room 111 has been repaired. **How will you identify other residents having the potential**	09/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 00 B. WING	09/10/2024

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	observed a six inch by six inch hole in Room 111. The hole was in the drywall above the residents room light. The hole was observed to have exposed wires. During an interview at that time, the Resident 86 who resided in that room was unaware of how long the hole with exposed wires had been there. On 9/5/24 at 9:00: a.m., observed the same. On 9/6/24 at 10:30 a.m., observed the same. On 9/9/24 at 9:57 a.m., observed the same. During an interview on 9/9/24 at 10:01 a.m., the Executive Director indicated she was not aware of the hole in Room 111. The Executive Director indicated the facility did not currently have a maintenance director. 3.1-19(f)		**to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All resident rooms have been assessed x1 and repairs performed as needed. ED/Designee will in-service staff on filling out maintenance repair forms when observing damaged areas by 9/30/24. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director/designee will perform facility rounds daily to identify problems or needed repairs ED/Designee will in-service staff on filling out maintenance repair forms when observing damaged areas by 9/30/24. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · ED/designee will be responsible for the completion Quality Control Environmental Checklist weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to ensure all residents have safe, functional, sanitary and comfortable	

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			environment. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.	