	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER 155237	X2) MULTIPLE CONSTRUCTION X3) DATE SURV. A. BUILDING 00 COMPLETED B. WING 09/10/2024		
	ROVIDER OR SUPPLIER Y VILLAGE	3518 S	ADDRESS, CITY, STATE, ZIP COD SHELBY ST IAPOLIS, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0000				
Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00442889 and IN00441467.	F 0000	F000	
	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 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences	F 0558	F558 Reasonable	09/30/2024
	Based on observation, interview, and record		Accommodations	05/13/0/2021

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

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 390911 Facility ID: 000142 If continuation sheet Page 1 of 14

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155237	B. WIN	NG		09/10/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			SHELBY ST		
RETHΔN	IY VILLAGE				IAPOLIS, IN 46227		
DETTIAN	. VILLAGE			INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL]]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE	
		failed to ensure reasonable			Needs/Preferences		
		needs for 1 of 8 residents			What corrective action(s) wil	I	
	observed. A call light was not within reach.				be accomplished for those		
	(Resident 86)				residents found to have been	า	
					affected by the deficient		
	Finding includes:				practice?		
					·Call light is within reach for		
	On 9/10/24 at 1:45 p.m., observed Resident 86 in bed. Resident 86's call light was hanging over the				Resident 86		
					How will you identify other		
	bed and was on the floor next to the residents				residents having the potential	al	
	bed, out of the reach of the resident.				to be affected by the same		
	During an interview at that time, the Assistant				deficient practice and what		
	Director of Nursing (ADON) indicated the call				corrective action will be take	n?	
	_	een within the reach of the			All residents have the		
	resident.				potential to be affected by the		
					alleged deficient practice.		
		2 a.m., the DON provided a			Observational rounds we		
		nt Bill of Rights, dated 12/2017,			completed by Care Companio		
		s the current policy being used			x1 to ensure that call lights are	e in	
	1 .	eview of the policy indicated,			reach for all residents.		
		has the right to a dignified			All staff will be in-service		
		rmination, and communication			call lights in reach for resident	-	
		persons and services inside			ED/designee on or before 9/30	J/24	
	and outside the com	ımunıty") NA//		
	2.1.2(**)(1)				What measures will be put in	ιτο	
	3.1-3(v)(1)				place or what systemic		
					changes you will make to		
					ensure that the deficient		
					practice does not recur? All staff will be in-service	don	
					call lights in reach for resident ED/designee on or before 9/30	-	
					Observational rounds wil		
					completed by Care Companio		
					daily to ensure that call lights		
					in reach for all residents.	aic	
					in reach for all restuents.		
					How the corrective action (s)	,	
					will be monitored to ensure t		
					deficient practice will not		

PRINTED: 11/04/2024 FORM APPROVED

FARTIMENT OF HEALTH AND HUMAN SERVICES						
ENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 0938-03			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED			
	155237	B WING	09/10/2024			

	OF CORRECTION	IDENTIFICATION NUMBER 155237	A. BUILDING B. WING	00	COMPLETED 09/10/2024
	PROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD S SHELBY ST NAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				recur, i.e., what quality assurance program will be p into place? ED/designee will be responsible for the completion the Call Light audit tool weekly 4 weeks, bi-monthly for 2 mon monthly for 6 months and ther quarterly to ensure all staff is compliant with ensuring call lig are in place and within reach to continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by ED. If the threshold of 95% is achieved an action plan will be developed to ensure compliant	the not
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8 Notice Requireme Transfer/Discharg Based on interview	nts Before	F 0623	F623 Notice Requirements Before Transfer/Discharge What corrective action(s) wil	09/30/2024
	provided to the Offi Care Ombudsman f written transfer and (Resident 39)	written notification was ice of the State Long-Term for 1 of 4 residents reviewed for discharge notification.		be accomplished for those residents found to have been affected by the deficient practice? Ombudsman notification of transfers was completed for	
	was reviewed. The not limited to, delus	.m., Resident 39's clinical record diagnoses include, but were sional disorder, severe tion, and mood disturbance.		Resident 39. How will you identify other residents having the potentiato be affected by the same deficient practice and what corrective action will be take All residents that transfer	

FORM CMS-2567(02-99) Previous Versions Obsolete

The Quarterly Minimum Data Set (MDS)

Event ID:

390911

Facility ID: 000142

If continuation sheet

from the facility have the potential

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING	00	COMPLETED		
		155237	B. WIN	NG		09/10/2024		
		1	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIER	8			SHELBY ST			
BETHAN	Y VILLAGE			INDIANAPOLIS, IN 46227				
	1				I	ı	-	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X:		
PREFIX	`	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG		R LSC IDENTIFYING INFORMATION	_	TAG		DAT	E	
	· ·	/1/24, indicated Resident 39			to be affected by the alleged			
	was severely cognit	lively impaired.			deficient practice. An audit wil			
	1 The ASC (American Senior Communities)				completed on all residents of t			
	The ASC (American Senior Communities) Hospital ER (Emergency Room/Department)				facility to ensure the Office of			
					state long term Care Ombuds			
		ed 3/18/24, indicated Resident			is notified on every facility-initi	ated		
	39 was transferred to the hospital Emergency Department on 3/18/24 at 8:06 a.m. The transfer				transfers.	<u>,</u>		
	was a facility-initia				What measures will be put in	to		
	was a facility-illitia	ied transfer.			place or what systemic			
	2 The ASC Hearite	al ED Transfor Form dated			changes will you make to ensure that the deficient			
	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				practice does not recur? An in-service will be			
		ty-initiated transfer.						
	transfer was a facili	ty-initiated transfer.			completed by ED/designee for			
	2 The ASC Hearite	al ER Transfer Form, dated			Social Services Director to inc			
	_	Resident 39 was transferred to a			notification of Ombudsman of	•		
		on 4/27/24 at 7:40 p.m. The			resident transferring from facil	ity		
		ty-initiated transfer.			by 9/30/24.			
	tialistei was a facili	ty-initiated transfer.			Monthly reminders have to set on the social services cale			
	1 The ASC Hospit	tal ER Transfer Form, dated			to send notifications to the	iluai		
	_	Resident 39 was transferred to			Ombudsman. Monthly report v	vill		
		nsferred to a psychiatric			be reviewed by IDT.	VIII		
		at 2:30 p.m. The transfer was a			How will the corrective actio			
	facility-initiated tra				(s) be monitored to ensure the			
	lacinty initiated tra				deficient practice will not			
	The clinical record	lacked documentation that the			recur, i.e., what quality			
		Long-Term Care Ombudsman			assurance program will be p	ut		
		ting, that Resident 39 had been			into place?			
	· ·	er facility in March 2024, April			The DNS/designee will be	.		
	2024, and May 202				responsible for the completion			
		••			theEmergency	·		
	During an interview	on 9/10/24 at 12:31 p.m., the			Transfer Notifications QA Too			
	_	ctor indicated Resident 39's			weekly times 4 weeks, bi-mon			
		rgency Department and to a			times 2 months, monthly times			
		was a facility-initiated transfer.			and then quarterly until contin			
		tate Long-Term Care			compliance is maintained for 2			
		ot been notified of Resident			consecutive quartersThe re			
		d transfers to another facility in			of these audits will be reviewe			
		2024, and May 2024.			the QAPI committee overseer	-		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155237	B. W	NG		09/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
DETLIAN	V.)/!!! A OF				SHELBY ST		
BETHAN	Y VILLAGE			INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					the ED. If a threshold of 100%	is	
	During an interview	on 9/10/24 at 1:00 p.m., the			not achieved, an action plan w	/ill	
	Administrator indic	ated the facility lacked a			be developed. Deficiency in th	is	
	specific policy rega	rding the Office of the State			practice will result in disciplina	ry	
	Long-Term Care Or	mbudsman notification of a			action up to and including	_	
	resident's facility-in	itiated transfer to another			termination of responsible		
	facility.				employee.		
	3.1-12(a)(6)(A)						
			İ				
F 0641	483.20(g)						
SS=D	Accuracy of Asses	ssments					
Bldg. 00							
	Based on interview	and record review, the facility	F 00	541	What corrective actions will I	be	09/30/2024
	failed to ensure an a	accurate Minimum Data Set			accomplished for those		
	(MDS) assessment	was completed for 2 of 4			residents found to have beer	1	
	residents reviewed	for accuracy of MDS			affected by the deficient		
	assessments. Falls v	were not coded correctly.			practice?		
	(Resident 35, Resid	ent 92)			MDS for Resident 35 and	92	
					for falls has been corrected.		
	Findings include:						
					How will you identify other		
		rd of Resident 35 was reviewed			residents having the potentia	al	
		m. The diagnoses included, but			to be affected by the same		
	were not limited to,	Parkinson's disease,			deficient practice and what		
		t, repeated falls, generalized			corrective action will be take	n?	
		yncope and collapse, and			All residents with falls hav	re	
	difficulty in walking	g not.			potential to be affected by the		
					alleged deficient practice		
	A Fall Event, dated	7/9/24, indicated an					
	unwitnessed fall. Re	esident 35 had left shoulder			The MDS coordinator will	be	
	pain that required x-	-rays to rule out fracture.			in-serviced by the ED/designe	e on	
					accurate coding on the MDS		
	A Quarterly MDS a	ssessment, dated 8/7/24,			assessment for falls		
		35 had not had any falls since					
	_	sessment, a Quarterly MDS			1 x audit of all residents w	/ho	
	assessment, dated for	or 5/10/24.			have experienced a fall has be	een	
					completed to ensure falls are		
	During an interview	on 9/9/24 at 10:50 a.m., the			coded accurately. Any inaccur	ate	
	MDS Coordinator in	ndicated the MDS assessment,			coding has been modified and		

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Event ID:

390911

Facility ID: 000142

If continuation sheet Page 5 of 14

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155237	B. W	ING		09/10/2024	
			<u> </u>	OTT DET	ADDRESS CITY STATE TO SEE		
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
DETUAN	\/\/!!!				SHELBY ST		
BETHAN	Y VILLAGE			INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		тс	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
	dated 8/7/24, should	d have indicated Resident 35			resubmitted.		
	had experienced fal	ls.					
	_						
	2. The clinical recor	rd of Resident 92 was reviewed			What measures will be put in	nto	
	on 9/5/24 at 1:03 p.	m. The diagnoses included, but			place or what systemic		
	were not limited to,	chronic obstructive pulmonary			changes will be made to		
	disease, unspecified	dementia, generalized muscle			ensure that the deficient		
	weakness, and age-	related physical debility.			practice does not recur?		
	A Fall Event, dated 7/7/24, indicated a witnessed				The MDS coordinator will	be	
	fall where Resident 92 stood and fell close to a				in-serviced by the ED/designe	e on	
	nursing station.				accurate coding on the MDS		
					assessment for falls		
	A Fall Event, dated	7/13/24, indicated a witnessed			Once weekly the DNS/desi	gnee	
	fall where Resident	92 stood from her chair and			will re-review all MDS		
	fell.				assessments for the week		
					identifying any residents with	falls	
	A Fall Event, dated	7/21/24, indicated an			to ensure accurate coding.		
	unwitnessed fall wh	nere Resident 92 was found by					
	staff sitting on the f	loor of their room.					
					How will the corrective actio	ns	
	_	ge MDS assessment, dated			be monitored to ensure the		
		Resident 92 had not had any			deficient practice will not		
		or MDS assessment, a			recur, i.e., what quality		
	Significant Change	assessment, dated for 5/19/24.			assurance program will be p	ut	
					into place?		
	_	v on 9/9/24 at 9:46 a.m., the					
		ndicated the MDS assessment,			MDS/designee will be		
	· · · · · · · · · · · · · · · · · · ·	lld have indicated Resident 92			responsible for the completion	ı of	
	had experienced fal	ls.			the MDS Accuracy QA tool		
		0/0/04 - 40.70			weekly for 4 weeks, bi-monthl	-	
	_	v on 9/9/24 at 10:50 a.m., the			2 months, monthly for 6 month		
		ndicated the facility followed			and then quarterly to ensure a		
	· ·	essment Instrument) guidelines			wound care practices in place	until	
	for MDS assessmer	nts.			continued compliance is		
					maintained for 2 consecutive		
	3.1-31(d)				quarters. The results of these		
					audits will be reviewed by the		
					QAPI committee overseen by		
					ED. If the threshold of 95% is	not	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	BUILDING <u>00</u>		COMPLETED	
		155237	B. WI	NG		09/10/	/2024
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t			SHELBY ST		
BETHAN	Y VILLAGE				IAPOLIS, IN 46227		
	. VILLY (OL						
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					achieved an action plan will be		
					developed to ensure complian	ice.	
F 0686	400 05/5\/4\/;\/;;\						
SS=D	483.25(b)(1)(i)(ii)	- Duay and I load Duages and					
Bldg. 00		Prevent/Heal Pressure					
Diag. 00	Ulcer Based on observation	on, interview, and record	EA	(06	F 686 Treatment Services to		00/20/2024
		failed to provide services to a	F 06	000	Prevent/Heal Pressure Ulcer		09/30/2024
	-	er on her right heel for 1 of 3			Free of Accident		
		for pressure ulcers. (Resident			Hazards/Supervision/Devices	s	
	86)	ior pressure areers. (Resident			i iuzai us/oupei visioii/Device:	•	
	00)				What corrective action(s) wil	ı	
	Finding includes:				be accomplished for those	•	
	1 manig morado.	residents found to have been		1			
	On 9/6/24 at 10:15	a.m., observed Resident 86's			affected by the deficient	•	
		n uncovered wound. The area			practice?		
	-	ith gauze (a protective			Resident 86 is receiving wo	und	
	covering).				care treatment per facility police		
	On 9/9/24 at 9:33 a.	.m., observed Resident 86's			How other residents having t	the	
	right heel. The wou	and on the right heel was			potential to be affected by th	е	
	observed to be unco	overed.			same deficient practice will be	ре	
					identified and what correctiv	е	
		a.m., observed the wound on			action(s) will be taken?		
	Resident 86's right l	heel to not be wrapped in			All residents with risk of s	kin	
	gauze.				impairment have the potential		
					be affected by the alleged defi	icient	
		a.m., the clinical record for			practice.		
		viewed. The diagnosis,			Nursing staff to be in-serv		
		ot limited to, type II Diabetes			on wound care treatments per	•	
	Mellitus.				policy on or before 9/30/24.		
		S ('1			Any resident with current		
		Score (a risk assessment tool			wounds/pressure areas were		
	-	elihood of developing pressure			assessed x1 to ensure current		
	* ·	24 indicated Resident 86 had a			treatments were in place per N	NID	
	very high risk for p	ressure utcers.			order.		
	A Dhygigiana Ordan	doted 8/27/24 indicated			What measures will be put in	ιιO	
		, dated 8/27/24, indicated vith normal saline, pat dry,			place or what systemic		
	_	ound bed, cover with board			changes will be made to		
					· ensure marrie dencient		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

390911

Facility ID: 000142

If continuation sheet Page 7 of 14

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	ETED
		155237	B. WIN	G		09/10/	2024
	PROVIDER OR SUPPLIER Y VILLAGE SUMMARY	STATEMENT OF DEFICIENCIE		3518 S	ADDRESS, CITY, STATE, ZIP COD SHELBY ST APOLIS, IN 46227 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000	Assistant Director of wound on Resident wrapped and was used during the observation on 9/8/24 at 3:45 p provided a policy tip Program, dated 5/20 current policy being review of the policy promote the prevent development; prompressure ulcers and additional pressure measures and treatmappropriate." 3.1-40(a)(2)	on 9/9/24 at 11:25 a.m., the of Nursing indicated the 86's heel should have been asure why it was not wrapped			practice does not recur? Nursing staff to be in-serv on wound care treatments per policy on or before 9/30/24. Observational rounds will completed by DNS/designee of to ensure wound care treatment 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 presponsible for the completion the Wound Dressing Audit QA weekly for 4 weeks, bi-monthly 2 months, monthly for 6 month and then quarterly to ensure a wound care practices in place continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by ED. If the threshold of 95% is achieved an action plan will be developed to ensure compliance.	be daily nts t ut of tool y for ns III until	
F 0689 SS=E Bldg. 00	review, the facility free from accident h potentially affecting	on, interview, and record failed to ensure the facility was nazards for 1 of 1 observation, g 36 of 56 self-mobile residents ity. A rubber hose used for	F 068	39	Bethany Village is respectfully requesting face to face IDR. What corrective action(s) wil be accomplished for those residents found to have		09/30/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2)		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLETED	
		155237	B. W	ING		09/10/2024	
			ı	CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2			SHELBY ST		
DETUAN	Y VILLAGE				IAPOLIS, IN 46227		
DETHAN	Y VILLAGE			INDIAN	IAPOLIS, IN 46221		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	fish tank maintenan	ce was located on the floor in			affected by the deficient		
	the middle of a wall	kway area that was used by the			practice?		
	residents. (500 hall))			No residents were affecte	d by	
					the alleged deficient practice		
	Finding includes:				Upon notification, caution	Į.	
					signs were put in place to ens	ure	
	During an observati	ion, on 9/6/24 from 9:00 a.m. to			residents were safe.		
	9:13 a.m., the follow	wing was observed on the					
	500-hall floor space	e between the resident pantry			How other residents having	the	
	and the resident lou	nge area:			potential to be affected by th	ie	
					same deficient practice will I	be	
	- A dark colored rul	bber hose, approximately one			identified and what correctiv	'e	
	inch in diameter and	d approximately 25 feet in			action will be taken?		
	length, was observe	ed in the middle of the walkway			·All self-mobile residents ha	ve	
	that ran from the res	sident pantry room (on the left			the potential to be affected by	the	
	side of the hall) to t	he resident lounge (on the			alleged deficient practice.		
	right side of the hal	l) of the 500-hall.			All staff in-service to be		
					completed by the ED/designed	e on	
	- Approximately ter	n feet from the lounge area, the			or before 9/30/24 regarding fa	cility	
	dark colored rubber	hose was observed to be			to be free of trip hazards		
	curled onto itself w	hich raised the hose			What measures will be put ir	nto	
	approximately two	inches from the floor.			place or what systemic		
					changes will be made to		
		ght feet from the lounge area,			ensure that the deficient		
		ober hose was raised above the			practice does not recur?		
	floor approximately	three inches from the floor.			All staff in-service to be		
					completed by the ED/designe		
	•	were observed watching			or before 9/30/24 regarding fa	cility	
	television in the res	ident lounge.			to be free of trip hazards		
	- No staff were visil	ble in the area where the dark			Observational rounds will	he	
	colored rubber hose				completed by the ED/designer		
	colored raccer hose	, was rocated.			daily to ensure facility is free f		
	- No caution sions v	were visible in the hallway near			trip hazards		
	_	ored rubber hose was located.			How the corrective actions v	vill	
					be monitored to ensure the		
	On 9/6/24 at 9:14 a	.m., LPN 2 was observed			deficient practice will not		
		ounge area toward the nurse's			recur, i.e., what quality		
	-	ss from the resident pantry			assurance program will be p	ut	
		terview at that time, LPN 2			into place?	-	
1	1				i iii.o piaoo i	1	

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155237	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/10/2024
	ROVIDER OR SUPPLIER Y VILLAGE		3518 S	ADDRESS, CITY, STATE, ZIP COD SHELBY ST IAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	should have been place on the 500-hall. The of any potential trip should have been in potential tripping have 26 of 56 self-rindependently without who had access to the On 9/6/24 at 2:16 place a copy of the American General Health and and indicated it was the facility. A revier recognized safety are eliminated or contropossiblemust be keep a lace of a part of the contropossiblemust be keep a lace of a part of the contropossiblemust be keep a lace of a part of the contropossiblemust be keep a lace of a part of	a.m., the Director of Nursing document that indicated there mobile (ability to move put staff assistance) residents the 500-hall. a.m. the Administrator provided from Senior Communities Safety Policies, dated 12/2023, at the current policy in use by the work of the policy indicated, "all and health hazards shall be olled as quickly as ept free and clean erials that could create a health		IDT will be responsible for the completion Quality Control Environmental Checklist week for 4 weeks, bi-monthly for 2 months, monthly for 6 months then quarterly to ensure all are building are free of accidents continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by ED. If the threshold of 95% is achieved an action plan will be developed to ensure complian	and ea of until the not
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs		F 0761	F761 Label/Storage of	09/30/2024
	interview, the facili- cart was locked and	ty failed to ensure a treatment I secured for 1 of 1 random ory Care Treatment Cart)	1 0/01	medications What corrective actions will accomplished for those residents found to have been	be

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155237	(X2) MUL A. BUIL B. WING	DING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/10/2024	
NAME OF F	PROVIDER OR SUPPLIEF	·			ADDRESS, CITY, STATE, ZIP COD		
BETHAN	Y VILLAGE				SHELBY ST APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG		DATI	3
		0 a.m. to 9:15 a.m., during stration pass observation, on			affected by the deficient practice?		
	the memory care unit, observed an unlocked				Treatment cart on memo	rv	
	treatment cart with no staff present in the area.				care is locked when not in use	- I	
	Multiple residents were observed wandering						
	around the unit. The treatment cart was easily				How other residents having		
	opened. Inside the unlocked cart, the following				potential to be affected by the		
		ts, included but were not			same deficient practice will		
	limited to:				identified and what corrective	/e	
	Two tubes contai	ning 30 grams of Nystatin			actions will be taken? All residents have the		
				potential to be affected by the			
	Topical Cream (a medicated cream was used to treat fungal or yeast infections on your skin). The				alleged deficient practice.		
		ream indicated "keep out of			A 1x audit will be comple	ted	
	reach".	1			by DNS/designee to ensure a		
					medication and treatment car		
		ng one ounce of vagisil cream			are locked when not in use.		
	,	on). The label on the tube of			An in-service will be		
	medicated cream in	dicated "keep out of reach".			completed by DNS/designee		
					before 9/30/24 with all license		
		ce jar of Aquaphor healing			nurses on medication/treatme		
	"keep out of reach	l on the ointment indicated			carts to be locked at all times		
	keep out of react	l			when not in use		
	_	v on 9/6/24 at 9:10 a.m., LPN 3			What measures will be put in	nto	
		nent cart should have been			place or what systemic		
	locked.				changes will be made to		
	During an interview	on 9/6/24 at 9:39 a.m., the			ensure that the deficient practice does not recur?		
		indicated the treatment cart			An in-service will be		
	should have been lo				completed by DNS/designee	on or	
					before 9/30/24 with all license		
	On 9/6/24 at 1:44 p	.m., the DON provided a			nurses on medication/treatme		
	document that indic	cated there were 20 of 25			carts to be locked at all times		
	cognitively impaire	d self-mobile residents residing			when not in use		
	on the Memory Car	e Unit.			Observational rounds wil	be	
					completed daily by nurse		
		.m., the Director of Nursing			managers/designee to ensure		
	provided a policy ti	tled Storage and Expiration			medication and treatment car	ts I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155237		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2024		
	ROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD S SHELBY ST NAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CTION SHOULD BE COMPLETION TO THE APPROPRIATE	
				are locked when not in use. A concerns will be addressed immediately.	ny	
				How the corrective actions to be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place? DNS/designee will be responsible for the completion the Medication Storage Revie audit tool weekly for 4 weeks, bi-monthly for 2 months, mon for 6 months and then quarter ensure all the carts are locked when not in use until continue compliance is maintained for consecutive quarters. The resof these audits will be reviewed the QAPI committee overseed the ED. If the threshold of 950 not achieved an action plan we developed to ensure compliant.	out n of thly tly to d d d d d d sults ed by n by % is	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/S	anitary/Comfortable Environ		developed to ensure compilar		
	interview, the facili atmosphere for 1 of homelike setting. D Resident 86) Finding included:	on, record review, and ty failed to ensure a homelike 8 rooms observed for a rywall was missing. (Room 111, e 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 bee affected by the deficient practice? Hole in room 111 has been repaired. How will you identify other residents having the potential	n en	

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f i		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155237	A. BUILDING <u>00</u> CO		(X3) DATE SURVEY COMPLETED 09/10/2024		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
BETHANY VILLAGE			3518 S SHELBY ST INDIANAPOLIS, IN 46227				
(X4) ID	4) ID SUMMARY STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION		
TAG			TAG	DEFICIENCY)	DATE		
		by six inch hole in Room 111.		to be affected by the same			
		drywall above the residents		deficient practice and what			
	-	le was observed to have		corrective action will be taken	1?		
	_	ing an interview at that time,	All residents have the				
		o resided in that room was		potential to be affected by the			
		ng the hole with exposed wires		alleged deficient practice.			
	had been there.			All resident rooms have be	een		
	0.0/5/24 + 0.00	1 1.4		assessed x1 and repairs			
	On 9/5/24 at 9:00: a	a.m., observed the same.		performed as needed.			
	0:: 0/6/24 -4 10:20	h		ED/Designee will in-servic			
	On 9/6/24 at 10:30 a.m., observed the same.			staff on filling out maintenance			
	On 9/9/24 at 9:57 a.m., observed the same.			repair forms when observing			
	On 9/9/24 at 9:57 a.	.m., observed the same.		damaged areas by 9/30/24.			
	During an interview on 9/9/24 at 10:01 a.m., the			What measures will be put in	10		
	_	indicated she was not aware of		place or what systemic			
				changes you will make to			
	the hole in Room 111. The Executive Director			ensure that the deficient			
	indicated the facility did not currently have a maintenance director.			practice does not recur? Maintenance			
	maintenance director.			director/designee will perform			
	3.1-19(f)			facility rounds daily to identify			
	3.1-17(1)			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	1		
				(s) be monitored to ensure th			
				deficient practice will not	-		
				recur, i.e., what quality			
				assurance program will be pu	ıt		
				into place?			
				· ED/designee will be responsil	ble		
				for the completion Quality Con			
				Environmental Checklist weekl			
				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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2024		
NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 3518 S SHELBY ST INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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	
				environment. The results of the audits will be reviewed by the QAPI committee overseen by ED. If the threshold of 95% is achieved an action plan will be developed to ensure compliant	the not		

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