STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155237	A. BUILDING -- B. WING	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHANY VILLAGE	3518 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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/23/24 Facility Number: 000142 Provider Number: 155237 AIM Number: 100266940 At this Emergency Preparedness survey, Bethany Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 100 certified beds. At the time of the survey, the census was 88. Quality Review completed on 09/25/24	E 0000	**Disclaimer:** **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of annual survey review on or after October 10th 2024.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/23/24 Facility Number: 000142 Provider Number: 155237 AIM Number: 100266940 At this Life Safety Code survey, Bethany Village was found not in compliance with Requirements	K 0000	**Disclaimer:** **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
KAVITA BERI	HFA,ED	10/03/2024

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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	for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. Building 0101 and Building 0202, the Therapy Room addition constructed in 2012, were each surveyed using Chapter 19, Existing Health Care Occupancies. This one story facility was surveyed as one building of Type V(000) construction. Building 0101 was determined to be of Type V (000) construction and fully sprinklered. Building 0202 was determined to be of Type V (111) construction and fully sprinklered. 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 88 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except for one detached storage shed. Quality Review completed on 09/25/24		**desk review in lieu of annual survey review on or after October 10th 2024.**	
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 walk-in freezers in the kitchen in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers	K 0351	POC for **tag K 351** **SS-D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Combustible boxes were	10/10/2024

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	shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect kitchen staff only. Findings include: Based on observations with the Executive Director, the Director of Property Management and the Field Maintenance Supervisor during a tour of the facility from 12:15 p.m. to 2:00 p.m. on 09/23/24, combustible boxes were stored up against the sidewall mounted sprinkler in the walk-in freezer in the kitchen which obstructed the discharge pattern for the sprinkler. Based on interview at the time of the observations, the Field Maintenance Supervisor agreed box storage in the walk-in freezer in the kitchen obstructed the spray pattern of the sidewall sprinkler installed in the freezer. These findings were reviewed with the Executive Director, the Director of Property Management and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		removed from the walk-in freezer in the kitchen which obstructed the discharge pattern for the sprinkler. **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 have the potential to be affected by the alleged deficient practice. All the facility sprinklers were audited to ensure that nothing is blocking the sprinklers. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director/designee will conduct an audit every two weeks to ensure that no sprinklers are obstructed at any time. If any deficient practice is identified, then the Maintenance director/designee will immediately remove the obstruction away from the sprinkler system. **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** Maintenance director /designee will be responsible for the completing the audit biweekly for 4 weeks, monthly for 6 months and then quarterly to ensure that sprinkler systems are not obstructed with anything. The	

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			results of these audits will be reviewed by the committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency will be completed by October 10th, 2024.	
K 0353 SS=D Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation and interview; the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 5.3.1.1.2 states where sprinklers are subjected to harsh environments, including all portions of indoor cold storage areas, on a 5-year basis, either sprinklers shall be replaced or representative sprinkler samples shall be tested. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, Section 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect over one kitchen staff and visitors in the facility. Findings include:	K 0353	POC for **tag K 353** **SS-D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Sprinklers in the walk-in freezer and cooler in the kitchen are tested and replaced now. **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 have the potential to be affected by the alleged deficient practice. All the facility sprinklers were audited to ensure that all dry pipe fire sprinklers are inspected and replaced. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director/designee will conduct an audit every two weeks	10/10/2024

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	Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 04/11/24 with the Executive Director, the Director of Property Management and the Field Maintenance Supervisor during record review from 9:40 a.m. to 12:15 p.m. on 09/23/24, deficiencies were noted for the facility's sprinkler systems. The "Deficiency Summary" section of the 04/11/24 sprinkler system inspection report stated, "Sprinklers subject to harsh environments replaced or successfully sample tested in last 5 years? Freezer: 21- 1/4 chrome 155 standard response sidewall 2-piece ugly. Cooler: 20" chrome 155 standard response sidewall 2-piece ugly. Will need 2 chrome wall plates and can of spray foam when replacing". Based on interview at the time of record review, the Field Maintenance Supervisor stated the harsh environment sprinklers in the walk-in freezer and cooler in the kitchen were not tested or replaced on or after 04/11/24. Based on observations with the Executive Director, the Director of Property Management and the Field Maintenance Supervisor during a tour of the facility from 12:15 p.m. to 2:00 p.m. on 09/23/24, one side wall sprinkler was installed in the walk-in freezer and one sidewall sprinkler was installed in the walk-in cooler in the kitchen. These findings were reviewed with the Executive Director, the Director of Property Management and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		to ensure that all dry pipe sprinklers are tested and replaced on time if needed. If any deficient practice is identified, then the Maintenance director/designee will immediately get the testing completed. **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** Maintenance director /designee will be responsible for the completing the audit biweekly for 4 weeks, monthly for 6 months and then quarterly to ensure that sprinkler systems are tested timely and replaced if needed. The results of these audits will be reviewed by the committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency will be completed by October 10th, 2024.	
K 0372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke			

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Bldg. 01	Barrie Based on observation and interview, the facility failed to ensure 1 of 6 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the corridor door set by Room 208. Findings include: Based on observations with the Executive Director, the Director of Property Management and the Field Maintenance Supervisor during a tour of the facility from 12:15 p.m. to 2:00 p.m. on 09/23/24, the annular space surrounding a four inch in diameter sprinkler pipe which penetrated the attic smoke barrier wall above the corridor door set by Room 208 was not firestopped. Based on interview at the time of the observations, the Field Maintenance Supervisor agreed the aforementioned opening in the smoke barrier wall above the corridor door set by Room 208 was not firestopped to maintain the fire resistance rating of the smoke barrier wall. These findings were reviewed with the Executive Director, the Director of Property Management and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0372	POC for **tag K 372** **SS-D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The smoke Barrier walls above the corridor set by room 208 is repaired. **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 have the potential to be affected by the alleged deficient practice. All the facility smoke barrier walls are audited to ensure smoke barrier walls are protected to maintain the fire resistance rating of the smoke barrier walls. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director/designee will conduct an audit every two weeks to ensure that no sprinklers are obstructed at any time. If any deficient practice is identified, then the Maintenance director/designee will immediately fix the smoke barrier wall to protected to maintain the fire resistance rating of the smoke barrier walls. . **how the corrective action(s)**	10/10/2024

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Maintenance director /designee will be responsible for the completing the audit biweekly for 4 weeks, monthly for 6 months and then quarterly to ensure that smoke barrier walls are protected to maintain the fire resistance rating of the smoke barrier wall. The results of these audits will be reviewed by the committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency will be completed by October 10th, 2024.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to maintain electrical receptacles in 1 of over 4 wall mounted outlet boxes in 1 of 50 resident sleeping rooms in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, at Article 110.12 (B) Integrity of Electrical Equipment and Connections states internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by	K 0511	POC for **tag K 511** **SS-D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Cover plate and the electrical receptacles in room 201 are replaced by new receptacles and cover plates. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	10/10/2024

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	corrosion, chemical action, or overheating. This deficient practice could affect one resident and staff in resident sleeping Room 201. Findings include: Based on observations with the Executive Director, the Director of Property Management and the Field Maintenance Supervisor during a tour of the facility from 12:15 p.m. to 2:00 p.m. on 09/23/24, the cover plate and both electrical receptacles in the wall mounted outlet box at the head of the resident bed nearest the corridor door in resident sleeping Room 201 had char marks indicating previous overheating. Both receptacles had electrical power when tested with an Ideal Industries GFCI receptacle testing device. Based on interview at the time of the observations, the Director of Property Management agreed the receptacles showed signs of overheating when electrical devices had been previously plugged into them. These findings were reviewed with the Executive Director, the Director of Property Management and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**action(s) will be taken.** All residents have the potential to be affected by the alleged deficient practice. All the facility covers plates and electric receptacles and are audited to ensure that electrical receptacles are maintained. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director/designee will conduct an audit every two weeks to ensure the electrical receptacles are maintained If any deficient practice is identified, then the Maintenance director/designee will immediately fix the receptacles. . **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** Maintenance director /designee will be responsible for the completing the audit biweekly for 4 weeks, monthly for 6 months and that electric receptacles are in accordance with NFPA 70 national electric code.The results of these audits will be reviewed by the committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be	

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			developed to ensure compliance. Deficiency will be completed by October 10th, 2024.	
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure smoking materials were deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 2 outdoor areas where smoking was taking place. This deficient practice could affect over 1 staff. Findings include: Based on observations with the Executive Director, the Director of Property Management and the Field Maintenance Supervisor during a tour of the facility from 12:15 p.m. to 2:00 p.m. on 09/23/24, over 20 cigarette butts were strewn on the ground outside the service hall exit by the maintenance office. A metal container with self-closing cover devices was not provided at this outdoor location where smoking was taking place. Based on interview at the time of the observations, the Field Maintenance Supervisor stated the area was a staff smoking area and agreed a metal container with self-closing cover devices was not provided at this outdoor location where smoking was taking place. These findings were reviewed with the Executive Director, the Director of Property Management and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0741	POC for **tag K 741** **SS-D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Smoking butts were collected and deposited into the ashtray and the area is cleaned. The metal container with self-closing cover over the device is provided at smoking location. **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 have the potential to be affected by the alleged deficient practice. All the facility smoking areas are audited to ensure that there is no cigarette butt were strewn on the ground. Smoking areas and metal container with self-closing cover over the device is provided at smoking location. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**	10/10/2024

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			Maintenance director/designee will conduct an audit daily to ensure that there is no cigarette butts were strewn on the ground and metal container with self-closing cover over the device is provided at smoking location. Staff who smoke were educated by ED/designee to ensure self-closing smoke receptables are used. . 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 Maintenance director /designee will be responsible for the completing the audit biweekly for 4 weeks, monthly for 6 months to ensure there is no cigarette butts were strewn on the ground and metal container with self-closing cover over the device is provided at smoking location. The results of these audits will be reviewed by the committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency will be completed by October 10th, 2024.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility	K 0920		10/10/2024

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	failed to ensure non-fused multiplug adapters were not used as a substitute for fixed wiring in 1 of 50 resident sleeping rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 302. Findings include: Based on observations with the Executive Director, the Director of Property Management and the Field Maintenance Supervisor during a tour of the facility from 12:15 p.m. to 2:00 p.m. on 09/23/24, the resident bed and a CPAP machine were plugged into a three plug multiplug adapter plugged into an electrical receptacle in the wall mounted outlet box above the resident bed nearest the corridor door in resident sleeping Room 302. Based on interview at the time of the observations, the Field Maintenance Supervisor agreed a multiplug adaptor was being used as a substitute for fixed wiring in resident sleeping Room 302. These findings were reviewed with the Executive Director, the Director of Property Management and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		POC for **tag K 920** **SS-E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The non fused multiplug adapter had been removed from room 302. **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 have the potential to be affected by the alleged deficient practice. All the facility is audited to check if there is non fused multiplug adapter in any area of the facility. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director/designee will conduct an audit every two weeks to ensure that there is ensure there is no non fused multiplug adapter in any area of the building. . **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** Maintenance director /designee	

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			will be responsible for the completing the audit biweekly for 4 weeks, monthly for 6 months to ensure there is no non fused multiplug adapter in any area of the building. The results of these audits will be reviewed by the committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency will be completed by October 10th, 2024.	