R MEDICARE & MEDIC	_			MB NO. 0938-039		
IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	COMI	COMPLETED	
	155237	B. WING	3	 09/2	3/2024	
PROVIDER OR SUPPLIER			3518 S SHELBY ST			
SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN O	DE CORRECTION	(X5)	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PF	REFIX (EACH CORRECTIVE ACT	TON SHOULD BE	COMPLETION	
REGULATORY OR	LSC IDENTIFYING INFORMATION	,		CY)	DATE	
conducted by the In accordance with 42 Survey Date: 09/23 Facility Number: 0 Provider Number: 100 At this Emergency Village was found i Preparedness Requi Medicaid Participat CFR 483.73. The facility has 100 the survey, the cens	diana Department of Health in CFR 483.73. 6/24 00142 155237 266940 Preparedness survey, Bethany n compliance with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 88.	E 000	The creation and sethis Plan of Correction for this provider of any constitute an admit provider of any constitute and setting the setting of the setting of the setting of the setting correction be constituted by the setting compliance and results of the setting of the settin	ction does not alission by this conclusion set ment of any violation pectfully 2567 Plan of asidered the Allegation of requests a u of annual or after		
Licensure Survey w Department of Heal 483.90(a). Survey Date: 09/23 Facility Number: 0 Provider Number: AIM Number: 1000 At this Life Safety 0	ras conducted by the Indiana th in accordance with 42 CFR 8/24 00142 155237 266940 Code survey, Bethany Village	K 000	The creation and a this Plan of Corre constitute an adm provider of any conforth in the statem deficiencies, or of of regulation. This provider results requests that this Correction be conformed to the conform	ction does not hission by this conclusion set hent of f any violation pectfully 2567 Plan of hisidered the Allegation of		
	An Emergency Preconducted by the In accordance with 42 Survey Date: 09/23 Facility Number: 0 Preparedness Requimedicaid Participat CFR 483.73. The facility has 100 the survey, the censure Survey we consult of the survey of the	TOF DEFICIENCIES OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155237 ROVIDER OR SUPPLIER Y VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR	TOF DEFICIENCIES OF CORRECTION IDENTIFICATION NUMBER 155237 ROVIDER OR SUPPLIER Y VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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: 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 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: 155237 AIM Number: 100266940 At this Life Safety Code survey, Bethany Village K 000	TO F DEFICIENCIES OF CORRECTION DENTIFICATION NUMBER 155237 ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/23/24 A Life Safety Code Recertification and State Licensure Survey, was conducted 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 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 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 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 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 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 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). The greation and this Plan of Correction be constituted and the provider of any conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). The greation and this Plan of Correction be constituted and the provider of any conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/23/24 A Life Safety Code Recertification and State Licensure Survey was conducted b	TO DEFICIENCIES DECORRECTION DESTIFICATION NUMBER 155237 ROVIDER OR SUPPLIER Y VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION A BUILDING SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION A Disclaimer: The creation and submission of this Plan of Correction does not constitute an admission by this provider 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. A Life Safety Code Recertification and State Licensure Survey was senducted by the Indiana Department of Health in accordance with 42 CFR 483.73. A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. 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 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 AlM Number: 100266940 At this Life Safety Code survey, Bethany Village 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 Correction be considered the Letter of Credible Allegation of Correction be considered the Letter of Credible Allegation of Correction be considered the Letter of Credible Allegation of Correction be considered the Letter of Credible Allegation of Correction be considered the Letter	

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

(X6) DATE

TITLE

KAVITA BERI HFA,ED 10/03/2024

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: 390921 Facility ID: 000142 If continuation sheet Page 1 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155237		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/23/2024		
	PROVIDER OR SUPPLIER	R	3518 S	ADDRESS, CITY, STATE, ZIP COD SHELBY ST JAPOLIS, IN 46227		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	Subpart 483.90(a), 2012 Edition of the Association (NFPA and 410 IAC 16.2. 0202, the Therapy I 2012, were each sur Existing Health Car This one story facil building of Type V 0101 was determined to be construction and fur was determined to be construction and fur a fire alarm system corridors and in all The facility has sme fire alarm system ir rooms. The facility a census of 88 at the All areas where residence were sprinklered an services were sprinklered an services were sprinklered storage shed.	ity was surveyed as one (000) construction. Building ed to be of Type V (000) lly sprinklered. Building 0202 be of Type V (111) lly sprinklered. The facility has with smoke detection in the areas open to the corridor. be detectors hard wired to the installed in all resident sleeping whas a capacity of 100 and had		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				
	failed to ensure the heads were not obst freezers in the kitch 19.3.5.1. NFPA 13 states sprinklers sha obstructions to disc	spray pattern for sprinkler tructed in 1 of 1 walk-in ten in accordance with LSC, 2010 edition, Section 8.5.5.1 all be located so as to minimize tharge as defined in 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		

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Event ID:

390921

Facility ID: 000142

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPLETED	
		155237	B. W	ING		09/23/2024	
			ı	CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			SHELBY ST		
DETLIAN	IY VILLAGE				IAPOLIS, IN 46227		
DETHAN	IT VILLAGE			INDIAN	IAPOLIS, IN 40221		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	shall be provided to	ensure adequate coverage of			removed from the walk-in free	zer in	
	the hazard. Section	s 8.5.5.2 and 8.5.5.3 do not			the kitchen which obstructed t	:he	
	permit continuous	or noncontinuous obstructions			discharge pattern for the sprin	ıkler.	
	less than or equal to	o 18 inches below the sprinkler			how other residents having	the	
	deflector or in a ho	rizontal plane more than 18			potential to be affected by the	ie	
	inches below the sp	orinkler deflector that prevent			same deficient practice will I	be	
	the spray pattern fr	om fully developing. This			identified and what corrective	/e	
	deficient practice c	ould affect kitchen staff only.			action(s) will be taken.		
					All residents have the potentia	al to	
	Findings include:				be affected by the alleged def	icient	
					practice. All the facility sprinkle	ers	
	Based on observati	ons with the Executive			were audited to ensure that		
	Director, the Direct	tor of Property Management			nothing is blocking the sprinkle	ers.	
	and the Field Main	tenance Supervisor during a			What measures will be put in	nto	
	tour of the facility	from 12:15 p.m. to 2:00 p.m. on		place and what systemic			
	09/23/24, combusti	ble boxes were stored up		changes will be made to			
	against the sidewal	l mounted sprinkler in the			ensure that the deficient		
	walk-in freezer in t	he kitchen which obstructed the			practice does not recur.		
	discharge pattern fo	or the sprinkler. Based on			Maintenance director/designe	e will	
		ne of the observations, the Field			conduct an audit every two we	eeks	
	_	visor agreed box storage in the			to ensure that no sprinklers ar	·e	
		he kitchen obstructed the spray			obstructed at any time. If any		
	pattern of the sidev	vall sprinkler installed in the			deficient practice is identified,	I	
	freezer.				the Maintenance director/desi	gnee	
					will immediately remove the		
	_	re reviewed with the Executive			obstruction away from the		
		tor of Property Management			sprinkler system.		
	and the Field Main	tenance Supervisor during the			how the corrective action(s)		
	exit conference.				will be monitored to ensure	the	
					deficient practice will not		
	3.1-19(b)				recur, i.e., what quality		
					assurance program will be p	ut	
					into place; and		
					Maintenance director /designe	e	
					will be responsible for the		
					completing the audit biweekly	I	
					weeks, monthly for 6 months	and	
					then quarterly to ensure that		
					sprinkler systems are not		
					obstructed with anything. The		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155237		A. BU	ILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/23/2024		
		155237	B. WI	NG		09/23/	2024
	PROVIDER OR SUPPLIER Y VILLAGE			3518 S	ADDRESS, CITY, STATE, ZIP COD SHELBY ST APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					results of these audits will be reviewed by the committee overseen by the ED. If the threshold of 95% is not achiev an action plan will be develope ensure compliance. Deficiency will be completed be October 10th, 2024.	ed to	
K 0353 SS=D Bldg. 01	NFPA 101 Sprinkler System -	- Maintenance and Testing					
	interview; the facili sprinkler systems in LSC 9.7.5 requires inspected, tested, and with NFPA 25, Star Testing, and Mainter Protection Systems. Section 5.3.1.1.2 star subjected to harsh exportions of indoor cobasis, either sprinkly representative sprin NFPA 25, Section 4 owner or designated or repair deficiencies found during the instruction of the ins	riew, observation and ty failed to maintain automatic accordance with NFPA 25. all sprinkler systems shall be ad maintained in accordance adard for the Inspection, anance of Water-Based Fire NFPA 25, 2011 Edition, attes where sprinklers are invironments, including all old storage areas, on a 5-year ers shall be replaced or kler samples shall be tested. A.1.4.1 states the property differentiative shall correct as or impairments that are spection, test and maintenance andard. Corrections and repairs by qualified maintenance fied contractor. NFPA 25, are records shall be made for all and maintenance of the system all be made available to the insidiction upon request. This build affect over one kitchen the facility.	K 03	353	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 kitche are tested and replaced now. how other residents having to 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 be affected by the alleged defi practice. All the facility sprinkle were audited to ensure that all pipe fire sprinklers are inspect and replaced. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance director/designed conduct an audit every two ween affected by the alleged definition of the place and what systemic changes will be made to ensure that the deficient practice does not recur.	he e e e l to cient ers l dry ed	10/10/2024

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Facility ID: 000142

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

PRINTED: 10/10/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155237	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	COMP	E SURVEY PLETED 3/2024
	PROVIDER OR SUPPLIEF		3518 \$	CADDRESS, CITY, STATE, ZIP CO S SHELBY ST NAPOLIS, IN 46227	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
V 0272	inspection contractor. Testing and Mainter Sprinkler Systems" with the Executive Property Managemes Supervisor during resulting 12:15 p.m. on 09/2; the facility's sprinkly Summary" section of inspection report standard establishment of the facility's sprinkly Summary" section report standard establishment of the facility's sprinkly Summary" section report standard environments sample tested in last chrome 155 standard ugly. Cooler: 20" of sidewall 2-piece ugle plates and can of spring Based on interview the Field Maintenant harsh environment and cooler in the kirreplaced on or after observations with the Director of Property Maintenance Superfacility from 12:15 one side wall sprinkly freezer and one side the walk-in cooler in the section of the price of the Director, the Director, the Director, the Director and the Field Maintenant exit conference.	The sprinkler system or's "Form for Inspection, nance of Dry Pipe Fire documentation dated 04/11/24 Director, the Director of ent and the Field Maintenance ecord review from 9:40 a.m. to 3/24, deficiencies were noted for ler systems. The "Deficiency of the 04/11/24 sprinkler system ated, "Sprinklers subject to a replaced or successfully to 5 years? Freezer: 21- 1/4 and response sidewall 2-piece chrome 155 standard response ly. Will need 2 chrome wall oray foam when replacing". at the time of record review, nee Supervisor stated the sprinklers in the walk-in freezer techen were not tested or 104/11/24. Based on the Executive Director, the y Management and the Field visor during a tour of the p.m. to 2:00 p.m. on 09/23/24, cler was installed in the walk-in ewall sprinkler was installed in the kitchen. The reviewed with the Executive or of Property Management tenance Supervisor during the		to ensure that all dry pi sprinklers are tested ar on time if needed. If an practice is identified, the Maintenance director/dimmediately get the test completed. how the corrective act will be monitored to election practice will recur, i.e., what quality assurance program winto place; and Maintenance director will be responsible for the completing the audit bis weeks, monthly for 6 methen quarterly to ensure sprinkler systems are to timely and replaced if meresults of these audits were reviewed by the commit overseen by the ED. If threshold of 95% is not an action plan will be densure compliance. Deficiency will be composited of 10th, 2024.	ind replaced by deficient en the esignee will sting stion(s) insure the not fill be put designee he weekly for 4 conths and e that ested leeded. The will be ttee the achieved eveloped to	
K 0372 SS=E	NFPA 101 Subdivision of Bui	ilding Spaces - Smoke				

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Event ID:

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Facility ID: 000142

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u> COMPLETED B. WING 09/23/2024			
		155237	B. W	ING		09/23/2	2024
	PROVIDER OR SUPPLIER			3518 S	ADDRESS, CITY, STATE, ZIP COD SHELBY ST APOLIS, IN 46227		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	1	ID	· 		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
Bldg. 01	Barrie						
		on and interview, the facility	K 0	372	POC for tag K 372		10/10/2024
		6 smoke barrier walls were			SS-D		
	-	in the fire resistance rating of			What corrective action(s) wil	I	
		rall. LSC Section 19.3.7.5 riers to be constructed in			be accomplished for those		
	•	C Section 8.5 and shall have a			residents found to have beer affected by the deficient	n	
		re resistive rating. This			practice?		
		ould affect over 20 residents,			The smoke Barrier walls abov	e the	
	-	the vicinity of the corridor			corridor set by room 208 is		
	door set by Room 2	08.			repaired.		
					how other residents having t	the	
	Findings include:				potential to be affected by th	I	
					same deficient practice will b	I	
		ons with the Executive			identified and what correctiv	е	
		or of Property Management enance Supervisor during a			action(s) will be taken.	.145	
		rom 12:15 p.m. to 2:00 p.m. on			All residents have the potentian be affected by the alleged defined by the alleged defined as the control of th		
	-	ar space surrounding a four			practice. All the facility smoke		
		rinkler pipe which penetrated			barrier walls are audited to en		
	-	ier wall above the corridor			smoke barrier walls are protec		
	door set by Room 2	08 was not firestopped. Based			to maintain the fire resistance		
		time of the observations, the			rating of the smoke barrier wa	lls.	
		Supervisor agreed the			What measures will be put ir	nto	
		ning in the smoke barrier wall			place and what systemic		
		loor set by Room 208 was not tain the fire resistance rating of			changes will be made to		
	the smoke barrier w				ensure that the deficient practice does not recur.		
	and smoke barrier w	W.1.			Maintenance director/designe	e will	
	These findings were	e reviewed with the Executive			conduct an audit every two we		
	_	or of Property Management			to ensure that no sprinklers ar	1	
	and the Field Maint	enance Supervisor during the			obstructed at any time. If any		
	exit conference.				deficient practice is identified,		
					the Maintenance director/desi	~ I	
	3.1-19(b)				will immediately fix the smoke		
					barrier wall to protected to		
					maintain the fire resistance rate of the smoke barrier walls.	urig	
					oi the smoke parrier walls.		
					how the corrective action(s)		

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

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155237	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/23/2024	
	PROVIDER OR SUPPLIER Y VILLAGE		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 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	
				will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place; and Maintenance director /designe will be responsible for the completing the audit biweekly weeks, monthly for 6 months then quarterly to ensure that smoke barrier walls are protect to maintain the fire resistance rating of the smoke barrier was The results of these audits wireviewed by the committee overseen by the ED. If the threshold of 95% is not achievan action plan will be developensure compliance. Deficiency will be completed to October 10th, 2024.	for 4 and cted ill. Il be	
K 0511 SS=D Bldg. 01	failed to maintain et 4 wall mounted out sleeping rooms in a National Electric Co Article 110.12 (B) I and Connections sta equipment, including insulators, and othe damaged or contamns such as paint, plasted corrosive residues. parts that may adve mechanical strength	en and interview, the facility dectrical receptacles in 1 of over let boxes in 1 of 50 resident ecordance with NFPA 70, ode. NFPA 70, 2011 Edition, at integrity of Electrical Equipment lets internal parts of electrical ag busbars, wiring terminals, or surfaces, shall not be inated by foreign materials er, cleaners, abrasives, or There shall be no damaged resely affect safe operation or a of the equipment such as an; bent; cut; or deteriorated by	K 0511	POC for tag K 511 SS-D What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice? The Cover plate and the elect receptacles in room 201 are replaced by new receptacles cover plates. how other residents having potential to be affected by the same deficient practice will identified and what corrective	nrical and the ne be	

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l f '			ULTIPLE CO	TIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	ORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u>		01	COMPLETED		
		155237	B. W	B. WING		09/23/	2024
	STREET ADDRESS, CITY, STATE, ZIP COD				ADDRESS CITY STATE ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			SHELBY ST		
 RETHAN	IY VILLAGE				NAPOLIS, IN 46227		
DETTIAN	TI VILLAGE			INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		l action, or overheating. This			action(s) will be taken.		
	_	ould affect one resident and			All residents have the potentia	ıl to	
	staff in resident sle	eping Room 201.			be affected by the alleged def	icient	
					practice. All the facility covers		
	Findings include:				plates and electric receptacles	3	
					and are audited to ensure that	t l	
	Based on observati	ons with the Executive			electrical receptacles are		
	Director, the Direc	tor of Property Management			maintained.		
	and the Field Main	tenance Supervisor during a					
	tour of the facility	from 12:15 p.m. to 2:00 p.m. on			What measures will be put in	ıto	
	09/23/24, the cover	r plate and both electrical			place and what systemic		
	_	vall mounted outlet box at the			changes will be made to		
	head of the residen	t bed nearest the corridor door			ensure that the deficient		
	in resident sleeping	g Room 201 had char marks			practice does not recur.		
	indicating previous	s overheating. Both receptacles			Maintenance director/designe	e will	
	had electrical power	er when tested with an Ideal			conduct an audit every two we	eks	
	Industries GFCI re	ceptacle testing device. Based			to ensure the electrical		
	on interview at the	time of the observations, the			receptacles are maintained If	any	
	Director of Propert	y Management agreed the			deficient practice is identified,	then	
	receptacles showed	l signs of overheating when			the Maintenance director/desi	gnee	
	electrical devices h	ad been previously plugged			will immediately fix the		
	into them.				receptacles.		
		re reviewed with the Executive			how the corrective action(s)		
		tor of Property Management			will be monitored to ensure t	:he	
		tenance Supervisor during the			deficient practice will not		
	exit conference.				recur, i.e., what quality		
					assurance program will be p	ut	
	3.1-19(b)				into place; and		
					Maintenance director /designe	e:e	
					will be responsible for the		
					completing the audit biweekly		
					weeks, monthly for 6 months a		
					that electric receptacles are in		
					accordance with NFPA 70 nat		
					electric code.The results of the	ese	
					audits will be reviewed by the		
					committee overseen by the El	O. If	
					the threshold of 95% is not		
					achieved an action plan will be	Э .	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155237	A. BUILDING B. WING	<u>01</u>	COMPLETED 09/23/2024
	PROVIDER OR SUPPLIER	2	3518 S	ADDRESS, CITY, STATE, ZIP COD SHELBY ST	
BETHAN	Y VILLAGE		INDIAN	IAPOLIS, IN 46227	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY	
K 0741 SS=D	NFPA 101 Smoking Regulati	LSC IDENTIFYING INFORMATION ONS	TAG	developed to ensure complian Deficiency will be completed b October 10th, 2024.	
Bldg. 01	failed to ensure smodinto ashtrays and moself-closing cover does a moself can be emptied of mosafe design in 1 of 2 was taking place. The affect over 1 staff. Findings include: Based on observation of the facility of the facility of the facility of the ground outside maintenance office. Self-closing cover does this outdoor location place. Based on into observations, the Findings was agreed a metal control devices was not prowhere smoking was the self-closing was the self-closing cover does not be self-closing cover does	evices into which ashtrays oncombustible material and 2 outdoor areas where smoking this deficient practice could ons with the Executive or of Property Management enance Supervisor during a from 12:15 p.m. to 2:00 p.m. on igarette butts were strewn on the service hall exit by the A metal container with evices was not provided at an where smoking was taking erview at the time of the eld Maintenance Supervisor a staff smoking area and ainer with self-closing cover vided at this outdoor location	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 collect and deposited into the ashtray the area is cleaned. The metal container with self-closing covover 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 be affected by the alleged defining practice. All the facility smokin areas are audited to ensure the there is no cigarette butt were strewn on the ground. Smokin areas and metal container with self-closing cover over the devis provided at smoking location. What measures will be put in	n cted r and l er he e oe e il to cient g at g n r/ice n.
		enance Supervisor during the		place and what systemic changes will be made to ensure that the deficient	

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practice does not recur.

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

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED 09/23/2024	
		155237	B. WI	NG		09/23/	/2024
	PROVIDER OR SUPPLIER			3518 S	ADDRESS, CITY, STATE, ZIP COD SHELBY ST 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Maintenance director/designed conduct an audit daily to ensure that there is no cigarette butts were strewn on the ground an metal container with self-closing cover over the device is provide smoking location. Staff who smoke were educated by ED/designee to ensure self-closing smoke receptables are used. Thow the corrective action(s) we monitored to ensure the deficit practice will not recur, i.e., who quality assurance program will put into place; and Maintenance director /designed will be responsible for the completing the audit biweekly weeks, monthly for 6 months to ensure there is no cigarette but were strewn on the ground and metal container with self-closing cover over the device is provided smoking location. The results of these audits will reviewed by the committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed ensure compliance. Deficiency will be completed by the comp	re d ng ded at ed s ill be ent at I be for 4 o utts d ng ded at I be	
K 0920 SS=E Bldg. 01	Extens	ent - Power Cords and	K 0	920	October 10th, 2024.		10/10/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/23/2024 155237 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3518 S SHELBY ST INDIANAPOLIS, IN 46227 **BETHANY VILLAGE** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to ensure non-fused multiplug adapters POC for tag K 920 were not used as a substitute for fixed wiring in 1 SS-E of 50 resident sleeping rooms. LSC 19.5.1 requires What corrective action(s) will utilities to comply with Section 9.1. LSC 9.1.2 be accomplished for those requires electrical wiring and equipment to comply residents found to have been with NFPA 70, National Electrical Code, 2011 affected by the deficient Edition. NFPA 70, Article 400.8 requires that, practice? unless specifically permitted, flexible cords and The non fused multiplug adapter cables shall not be used as a substitute for fixed had been removed from room 302. wiring of a structure. LSC Section 4.5.7 states any how other residents having the building service equipment or safeguard provided potential to be affected by the for life safety shall be designed, installed and same deficient practice will be approved in accordance with all applicable NFPA identified and what corrective standards. This deficient practice could affect action(s) will be taken. over 10 residents, staff and visitors in the vicinity All residents have the potential to of resident sleeping Room 302. be affected by the alleged deficient practice. All the facility is audited Findings include: to check if there is non fused multiplug adapter in any area of Based on observations with the Executive the facility. Director, the Director of Property Management and the Field Maintenance Supervisor during a What measures will be put into tour of the facility from 12:15 p.m. to 2:00 p.m. on place and what systemic 09/23/24, the resident bed and a CPAP machine changes will be made to were plugged into a three plug multiplug adapter ensure that the deficient plugged into an electrical receptacle in the wall practice does not recur. mounted outlet box above the resident bed Maintenance director/designee will nearest the corridor door in resident sleeping conduct an audit every two weeks Room 302. Based on interview at the time of the to ensure that there is ensure observations, the Field Maintenance Supervisor there is no non fused multiplug agreed a multiplug adaptor was being used as a adapter in any area of the building. substitute for fixed wiring in resident sleeping Room 302. how the corrective action(s) These findings were reviewed with the Executive will be monitored to ensure the Director, the Director of Property Management deficient practice will not and the Field Maintenance Supervisor during the recur, i.e., what quality exit conference. assurance program will be put into place; and 3.1-19(b) Maintenance director /designee

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

PRINTED: 10/10/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155237	IBER A. BUILDING <u>01</u> COMPLETED		(X3) DATE SURVEY COMPLETED 09/23/2024
	PROVIDER OR SUPPLIEF		3518 S	ADDRESS, CITY, STATE, ZIP COD SHELBY ST APOLIS, 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
	REGULATORI OF			will be responsible for the completing the audit biweekly 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 reviewed by the committee overseen by the ED. If the threshold of 95% is not achieve an action plan will be developed ensure compliance. Deficiency will be completed by October 10th, 2024.	for 4 o of I be ed ed to

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