STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 00 B. WING	12/01/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00416420. Complaint IN00416420 - Federal/State deficiencies related to the allegations are cited at F690 and F880. Unrelated deficiency is cited. Survey dates: November 29, 30, and December 1, 2023 Facility number: 000142 Provider number: 155237 AIM number: 100266940 Census Bed Type: SNF/NF: 91 Total: 91 Census Payor Type: Medicare: 6 Medicaid: 70 Other: 15 Total: 91 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 4, 2023.	F 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 December 20th, 2023.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
KAVITA BERI	HFA,ED	12/18/2023

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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	assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview, and record review, the facility failed to provide care and services to a resident with a suprapubic catheter (a urinary catheter that is inserted through the skin and advanced to the bladder to drain urine) for 1 of 3 residents reviewed. (Resident C) Finding includes:	F 0690	**POC for tag 690** **SS-d** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident C urinary catheter bag	12/20/2023

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	During an interview on 11/29/23 at 9:41 a.m., Resident C indicated the catheter bag should have been hung under the wheelchair. At that time, observed the top half of a urinary drainage bag sticking out of a tight pocket on the back of Resident C's wheelchair. The bottom half of the drainage bag appeared to have been stuffed into the pocket so the urine only be emptied into the top half of the drainage bag. The top half of the drainage bag appeared to be full and was connected to a dense, clear plastic tube that extended from the catheter drainage bag on the back of the wheelchair, down and under the wheelchair and to Resident C's left pant leg. The length of the plastic tube from the drainage bag to Resident C's left pant leg was also full of yellow fluid. Resident C was not sure how long ago the catheter bag was placed in the back pocket of the wheelchair but could remember it was placed there by staff that provided assistance earlier that morning. Resident C was not able to remember if she had been treated for a urinary tract infection recently but was tested for a urinary tract infection. During an interview on 11/29/23 at 10:04 a.m., QMA 1 (Qualified Medication Aide) indicated Resident C's catheter bag should have been placed below the Resident C's bladder. QMA 1 was not sure how long the catheter bag was in the back pocket of Resident C's wheelchair. During an interview on 11/29/23 at 10:05 a.m., CNA 1 (Certified Nursing Aide) indicated Resident C's catheter bag was placed in the back pocket of the wheelchair by night shift. Night shift ended at 7:00 a.m. The catheter bag was like that when CNA 1 came on to work. The clinical record for Resident C was reviewed		was immediately placed in the bottom close to left leg. **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 residents with catheter bags were observed by DNS/designee to ensure catheter bag was hanging properly. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** **The DNS/designee will conduct rounds each shift to ensure catheter bags are hung appropriately to allow proper drainage.** All nursing staff were in serviced regarding catheter bags and ensuring proper drainage of the bags by DNS/Designee.	

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	on 12/1/23 at 10:28 a.m. The diagnoses included, but were not limited to, breast cancer, neurogenic bladder, and atrial fibrillation. A quarterly MDS (Minimum Data Set) assessment, dated 10/29/23, indicated Resident C was severely cognitively impaired and had a urinary catheter. A progress note, dated 11/7/23 at 11:49 a.m., indicated new orders for a urinalysis with culture and sensitivity was ordered. A nurse practitioner progress note, dated 11/8/23 at 5:48 a.m., indicated on 11/7/23, a urinalysis with culture and sensitivity was ordered due to behaviors. A social services note, dated 11/8/23 at 9:48 a.m., indicated Resident C was putting feces on her face, hair, and mouth, and cursing and yelling at staff. Attempted to clean Resident C three times and was successful. Resident has order for a urinalysis to check for infection. The clinical record lacked a urinalysis being collected on 11/7/23. A progress note, dated 11/10/23 at 1:35 p.m., (3 days after the urinalysis was initially ordered) indicated collected urine correctly by foley catheter. A lab result, dated 11/13/23 at 5:38 a.m., indicated a urinalysis was collected on 11/10/23. Three or more organisms were identified suggesting contamination at collection. Suggest repeat culture. Verified 11/11/23 at 2:07 p.m. The lab was first printed at the facility on 11/13/23 at 5:38 a.m.		**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** DNS/designee will be responsible for the completion of audits to ensure all appropriate catheter care is provided. Audits will be completed weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to ensure appropriate catheter care is provided until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency completed by December 20th 2023.	

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	A lab result, dated 11/16/23 at 5:19 a.m., indicated a urinalysis was collected on 11/14/23 (7 days after the urinalysis was initially ordered). Three or more organisms were identified suggesting contamination at collection. Suggest repeat culture. Verified on 11/15/23 at 10:51 a.m. The lab was first printed at the facility on 11/16/23 at 5:19 a.m. A physician's order initiated on 11/17/23, indicated repeat urinalysis with culture and sensitivity. The physician's order had not been completed or discontinued as of 12/1/23. On 12/1/23 at 1:10 p.m., the facility was unable to provide a policy by survey exit. This tag relates to Complaint IN00416420. 3.1-41(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment			

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	and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to provide care and services for a resident that required continuous g-tube (gastric tube that is inserted into the skin and advanced to the stomach used to provide nutrients) feedings for 1 of 2 residents reviewed. (Resident B) Finding includes: On 11/29/23 at 9:49 a.m., observed Resident B laying in bed with the head of bed elevated. Next to Resident B's bed, at the top of a pole approximately 6 feet tall, was a hard plastic bottle with approximately 900 ml (milliliters) of tan liquid. The label on the plastic bottle indicated Glucerna 1.5 (a tube feeding used for residents with diabetes), dated 11/28/23 at 8:30 a.m., (approximately 25 hours before observation), and administer 50 ml per hour. The hard plastic bottle held 1000 ml of feeding. Next to the bottle was a clear plastic bag approximately half full with clear liquid. The label on the clear bag indicated Resident B and 45 ml per hour. There was a thin tube coming from the bottom of the plastic bag and plastic bottle that came together and down into a g-tube pump (mechanical pump that administers tube feeding and water flushes at a rate and in intervals ordered by the physician. The pump is set by the nurse). The pump's screen indicated the feeding rate was set to 50 ml per hour and the water flush was set to 45 ml per hour. A thin tube coming from the bottom of the pump extended under Resident B's blanket.	F 0693	**POC for tag 693** **SS-D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B'S G-tube was held and then the bed was raised to 30 degrees. Also, the g tube feeding was checked and restarted. **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 other residents feeding tubes were checked to ensure feeding tubes are used per physicians orders. All nursing staff have been educated related to caring for residents with tube feedings by DNS/designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	12/20/2023

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	On 11/29/23 at 10:59 a.m., Resident B was lying in bed with the head of the bed elevated. Resident B's g-tube feeding was turned on and feeding was being administered. CNA 1 (Certified Nursing Aide) used the bed control and laid Resident B to a flat position. At that time, CNA 2 was standing approximately 5 feet from Resident B, and indicated Resident B's g-tube feeding should have been placed on hold before she was laid flat. Then CNA 1 indicated a nurse had to put the g-tube feeding on hold. With Resident B still lying flat, CNA 1 stood next to Resident B's bed and CNA 2 left the room to get a nurse. After approximately 60 seconds, CNA 2 returned with the ADON (Assistant Director of Nursing). The ADON indicated Resident B's g-tube feeding should have placed on hold before laying the bed to a flat position. The ADON walked to the g-tube pump to place the g-tube feeding on hold. Then, the ADON pressed a button, on the pump, to flush the feeding tube with water. After approximately 15 seconds, the flush completed. The ADON placed the pump on hold and disconnected the feeding tube from Resident B's g-tube. At that time, the ADON indicated Resident B should not have received a water flush while she was lying flat. The feeding should have been placed on hold. The ADON was not sure why the date on the plastic bottle indicated the bottle was opened and hung for approximately 25 hours and only 100 ml of feeding was used from the bottle. According to the administration rate the bottle would have ran out approximately 5 hours ago. The feeding bottle and bag of water flush should have been labeled with Resident B's name, the date and time the bottle was opened and hung on the pole, what was being administered, the prescribed feeding rate, and the nurse that hung the bottle should have initialed the label. The ADON indicated she		**practice does not recur.** An audit will be created to ensure residents with gastric tube is provided appropriate care. DNS/Designee will conduct rounds each shift to ensure residents with tube feedings are receiving appropriate care and per physicians orders. **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** DNS/designee will be responsible for the completion of audits to ensure all appropriate gastric tube care is provided. Audits will be completed weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to ensure appropriate catheter care is provided until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	would ask the nurses who hung the feeding bottle. On 11/29/23 at 11:21 a.m., the ADON entered Resident B's room carrying a new bottle of tube feeding, a new clear bag with the thin tubes and indicated she could not find any nurse that opened and hung Resident B's bottle of tube feeding, dated 11/28/23 at 8:30 a.m., the ADON opened and hung a new bottle of tube feeding and bag of water flush. On 12/1/23 at 8:20 a.m., observed Resident B's g-tube feeding bottle that was hung on a pole next to the bed. The bottle, dated 12/1/23 at 6:45 a.m. (approximately 1.5 hours prior to observation), indicated Glucerna 1.5 administered at 50 ml per hour. The tube feeding bottle was full with 1000 ml tan fluid. Next to the hard plastic bottle of tube feeding was a clear plastic bag, dated 12/1/23 at 6:45 a.m. The bag was filled to the lid with clear fluid. The tube feeding pump was turned on and tube feeding was moving down the tube toward Resident B. A piston syringe (large syringe used to administer water flushes and medication though the g-tube) was sitting on Resident B's bedside table. The piston syringe was not dated. At that time, LPN 1 (Licensed Practical Nurse) entered Resident B's room. LPN 1 was not able to explain why Resident B's g-tube feeding was opened and hung, on 12/1/23 at 6:45 a.m., but the bottle of feeding and water flush bag were both full according to the manufacturer's label on the bottle. LPN 1 indicated according to the date and time the bottle was opened and hung, the bottle should have had approximately 925 ml remaining in the bottle. LPN 1 brought an unopened bottle of Glucerna 1.5 to compare the amount of feeding in the opened bottle with the unopened bottle. When LPN 1 compared the bottles next to each		Deficiency will be completed by December 20th 2023.	

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	other, both bottles appeared to be filled with the same amount of fluid. LPN 1 was not sure if or when the g-tube feeding pump had been serviced to ensure the pump worked properly. The clinical record for Resident B was reviewed, on 11/29/23 at 12:14 p.m. The diagnoses included, but were not limited to, subarachnoid hemorrhage, diabetes, aphasia (difficulty communicating effectively), and dysphagia (difficulty swallowing effectively). A quarterly MDS (Minimum Data Set) assessment, dated 10/20/23, indicated Resident B was severely cognitively impaired and received tube feeding. A current physician's order initiated, on 10/9/23, indicated Glucerna 1.5 administered at 50 ml per hour. A current physician's order initiated, on 10/9/23, indicated flush g-tube with 45 ml every hour. A current physician's order initiated, on 7/26/23, indicated Resident B could not have anything by mouth. On 11/30/23 at 8:30 a.m., the DON (Director of Nursing) provided a copy of a facility document, titled Enteral Tube Procedure, dated 1/2010, and indicated this was the current skills competency for a licensed nurse. A review of the document indicated maintain the head of the bed at 30 degrees at all times. 3.1-44(a)(2)			
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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Bldg. 00	§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:			

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	(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure that a glucometer (machine used to test a resident's blood sugar by blood drop), that was used for multiple residents, was disinfected before entering a resident's room to test the resident's blood sugar for 1 of 1 observations. (Resident B, QMA 1) Finding includes:	F 0880	**POC for tag 880** **SS-D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** QMA 1 was immediately in service about infection control and was	12/20/2023

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	On 11/29/23 at 1:07 p.m., observed QMA 1 (Qualified Medication Aide) take a glucometer, test strip (a small strip inserted into the glucometer where a blood drop is applied so the glucometer can give a blood sugar result), alcohol wipe, and a lancet (small device used to puncture the skin so a blood drop can be collected) out of the medication cart on the 100 hall. QMA 1 gathered the supplies and walked away from the cart toward resident rooms. QMA 1 entered Resident B's room and indicated she entered Resident B's room to check Resident B's blood sugar with the supplies she carried. QMA 1 indicated she last disinfected the glucometer around 9:00 a.m. when she checked the last blood sugar. QMA 1 then exited Resident B's room and walked back to the medication cart on 100 hall. QMA 1 opened a germicidal bleach wipe and wiped the glucometer until the entire glucometer was wet. QMA 1 set the glucometer down directly on the medication cart surface without a barrier. After waiting approximately 4 minutes (appropriate waiting time for the germicidal bleach wipe), QMA 1 indicated she was ready to check Resident B's blood sugar now. The glucometer that QMA 1 took to Resident B's room to check Resident B's blood sugar was used for all the residents, on the 100 hall, that required a finger to be punctured to collect a blood drop. At that time, the ADON (Assistant Director of Nursing) indicated the glucometer should have been placed on a clean barrier after the glucometer was disinfected with the germicidal bleach wipe, the glucometer should have been disinfected before QMA 1 walked into Resident B's room when QMA 1 was initially going to check Resident B's blood sugar. During an interview on 11/30/23 at 11:47 a.m., the DON (Director of Nursing) indicated there were 4		asked to show a return redemonstration for the glucometer use. **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 nursing staff was in service for infection control and use of glucometer. The Director of Nursing has not observed any other episodes of noncompliance until now however, if a concern is identified, the DON will in-service the staff immediately She will also give written counseling for continued noncompliance. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The DNS/designee will conduct rounds each shift to observe infection control techniques for disinfection glucometers. Any issues identified will immediately be corrected with the appropriate disinfection technique.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 00 B. WING	12/01/2023

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

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	residents that resided on the 100 hall that required a finger stick, with a lancet, to collect the drop of blood for the glucometer reading. On 11/30/23 at 8:30 a.m., the DON provided a copy of a document, titled Blood Glucose Meter Cleaning/Disinfecting and Testing, dated 7/2011, and revised, on 10/17/23. A review of the document indicated place a paper towel, plastic cup, or other clean barrier on a hard surface. Wipe entire surface of the glucometer with a germicidal wipe approved for use on a glucometer and allow the surface to remain wet for 3 minutes. Place cleaned glucometer on the paper towel, in the plastic cup, or on the clean barrier. Allow the glucometer to completely dry. This tag relates to Complaint IN00416420. 3.1-18(b)(1)		**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** DNS/designee will be responsible for the completion of audits to ensure all steps of infection control are followed including but not limited to glucometer care. Audits will be completed weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to ensure appropriate catheter care is provided until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency completed by December 20th 2023.	