STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 00 B. WING	09/29/2023

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00417827 and IN00418258. Complaint IN00417827 - No deficiencies related to the allegations are cited. Complaint IN00418258 - No deficiencies related to the allegations are cited. Survey dates: September 26, 27, 28, and 29, 2023 Facility number: 000142 Provider number: 155237 AIM number: 100266940 Census Bed Type: SNF/NF: 93 Total: 93 Census Payor Type: Medicare: 4 Medicaid: 74 Other: 15 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 3, 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 post annual survey review on or after October 19th, 2023.**	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered			

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

KAVITA BERI | HFA | 10/12/2023

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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	care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			

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	§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to ensure a resident centered comprehensive care plan was developed for 1 of 3 residents reviewed for wanderguards and 1 of 5 residents reviewed for oxygen therapy. A care plan for wanderguards and C-PAP machine use was not developed. (Resident 78, Resident 83) Findings include: 1. On 9/27/23 at 11:41 a.m., Resident 78 was observed in the activity room. Resident 78 was observed wearing wanderguard device (a device allows an individual the freedom to move about the unit yet remain safe if they attempt to leave the area) on his right ankle. On 9/27/23 at 12:54 p.m., Resident 78's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. Physician orders included, but were not limited to, "wanderguard ...start date: 8/4/23" and no end date noted. The August 2023 MAR/TAR (Medication Administration Record/Treatment Administration Record) indicated starting on 8/4/23 Resident 78's wanderguard was in position on a daily basis. The September 2023 MAR/TAR indicated Resident 78's wanderguard was in position on a daily basis.	F 0656	**POC for Tag F656** **SS-D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A comprehensive person-centered care plan has been developed and placed in the medical record for resident 78 for wearing wander guard on the right ankle. Also Care plan for resident 83 has been developed and placed in medical records for C-PAP. **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 residents having wander guard and C-PAP will be reviewed by DON/Designee to ensure care plans are in place by October 13th, 2023. If any deficient practice is identified, then the DON/designee will review the care plan in morning meeting and would	10/19/2023

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	The Admission Minimum Data Set (MDS) assessment, dated 7/28/23, indicated Resident 78 was severely cognitively impaired. The clinical record lacked a care plan related to Resident 78's wanderguard. Resident 78's Elopement Risk Assessment, dated 8/7/23, indicated Resident 78 was assigned a wanderguard. During an interview on 9/28/23 at 3:45 p.m., the Memory Care Coordinator indicated Resident 78 had been exhibiting exit seeking behaviors. On 8/4/23, the physician ordered a wanderguard monitor for Resident 78. The care plan should have been updated at the time of the physician's order for the placement of the wanderguard. 2. On 9/26/23 at 10:34 a.m., Resident 83 was observed in his room and resting on his bed. A C-PAP machine (continuous positive airway pressure therapy system) was observed at the bedside. The machine was turned to the on position with the tubing going from the machine to the C-PAP mask. The C-PAP mask was in place on Resident 83's face. On 9/26/23 at 11:16 a.m., the same was observed. On 9/28/23 at 3:43 p.m., Resident 83's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, sleep apnea (potentially serious sleep disorder in which breathing repeatedly stops and starts), and asthma. Physician orders included, but were not limited to, "C-PAP machine, setting at 11.0", on at bedtime		immediately develop and place a new care plan. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** th, 2023, for the care plan review. If any deficient practice is identified, then the DON/designee will review the care plan in morning meeting and would immediately develop and place a new care plan. An audit will be completed. Any resident who has a new order for wander guards and C-pap care plans will be reviewed by IDT to ensure a care plan has been developed. **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** weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to ensure all care plans are developed and in place until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	and off in the morning, "start date: 7/19/23" and no end date noted. The July 2023 MAR/TAR (Medication Administration Record/Treatment Administration Record) indicated starting on 7/19/23 Resident 83 utilized the C-PAP treatment on a daily basis. The August 2023 MAR/TAR indicated Resident 83 utilized the C-PAP treatment on a daily basis. The September 2023 MAR/TAR indicated Resident 83 utilized the C-PAP treatment on a daily basis. The Quarterly Minimum Data Set (MDS) assessment, dated 9/12/23, indicated Resident 83 was moderately cognitively impaired. The clinical record lacked a care plan related to Resident 83's C-PAP use. During an interview on 9/28/23 at 3:50 p.m., Resident 83 indicated he had used the C-PAP machine "for a long time" and was able to independently put the mask on and take it off as needed. During an interview on 9/28/23 at 3:55 p.m., the Memory Care Coordinator indicated Resident 83's physician ordered the C-PAP machine on 7/19/23 due to sleep apnea. Resident 83 had been using the C-PAP machine since that time. Resident 83 was able to independently put the C-PAP mask on and take it off. The care plan should have been updated when the physician ordered the C-PAP machine. On 9/28/23 at 4:00 p.m., the Memory Care Coordinator provided a copy of the IDT		Deficiency completed by October 19th, 2023.	

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	(Interdisciplinary team) Comprehensive Care Plan Policy, dated August 2023, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...the care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being...care plan problems, goals, and interventions musts be reviewed and revised by the interdisciplinary team periodically..." 3.1-35(a)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to date and label oxygen tubing for 4 of 5 residents reviewed for oxygen. (Resident 148, Resident 63, Resident 36, Resident 146) Finding includes: 1. During an interview on 9/26/23 at 8:55 a.m., Resident 148 indicated he constantly needed the oxygen delivery from the machine and nasal cannula.	F 0695	**POC for tag 695** **SS-E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 148,63,146 unlabeled oxygen humidifier bottle and oxygen tubing were discarded immediately, and new oxygen	10/19/2023

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	On 9/26/23 at 11:00 a.m., Resident 148 was observed in bed in his room receiving 2 liters of oxygen via a nasal cannula from an oxygen concentrator machine (a machine that takes in air from the room to filter out nitrogen in order to provide higher amounts of oxygen for oxygen therapy). The oxygen humidifier bottle and oxygen tubing were not labeled with a time or date. On 9/27/23 at 8:20 a.m., Resident 148 was observed in his room receiving 2 liters of oxygen via a nasal cannula from an oxygen concentrator. The oxygen humidifier bottle and oxygen tubing were not labeled with a time or date. On 9/28/23 at 1:30 p.m., Resident 148's clinical record was reviewed. The physician's orders included, but were not limited to: - 2 liters oxygen per nasal cannula, dated 9/5/23. - Change oxygen tubing and humidity, clean concentrator and filter, once a day on Sunday, dated 9/6/23. 2. On 9/26/23 at 12:19 p.m., Resident 63 was observed in his. The resident was sitting in his wheelchair, receiving 2 liters of oxygen via a nasal cannula from an oxygen concentrator, The oxygen humidifier bottle and oxygen tubing were not labeled with a time or date. On 9/27/23 at 8:30 a.m., Resident 63 was observed in room receiving 2 liters of oxygen via a nasal cannula from an oxygen concentrator. The oxygen humidifier bottle and oxygen tubing were not labeled with a time or date. 3. On 9/26/23 at 1:35 p.m., Resident 36 was observed in bed in his room receiving 2 liters of		humidifier bottle and oxygen tubing was placed with labeled to include time or date. **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 residents who need respiratory care and tracheostomy care and tracheal suctioning are provided with such care consistent with professional standards of practice. All the oxygen humidifier bottles and oxygen tubing were inspected to ensure labeling with time or date will be reviewed by DON/Designee by October 13th, 2023. If any deficient practice is identified, then the DON/designee will in-service the nursing staff immediately. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** DNs/designee will conduct an in-service for nursing staff by October 13th, 2023, for the respiratory care review including labeling with time or date for	

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	oxygen via a nasal cannula from an oxygen concentrator machine. The oxygen humidifier bottle and oxygen were not labeled with a time or date. On 9/27/23 at 8:44 a.m., Resident 36 was observed in his room receiving 2 liters of oxygen via a nasal cannula from an oxygen concentrator. The oxygen humidifier bottle and oxygen tubing were not labeled with a time or date. 4. On 9/26/23 at 1:53 p.m., Resident 146 was observed in bed in his room receiving 2 liters of oxygen via a nasal cannula from an oxygen concentrator machine. The oxygen humidifier bottle and oxygen tubing were not labeled with a time or date. On 9/27/23 at 8:15 a.m., Resident 146 was observed in his room receiving 2 liters of oxygen via a nasal cannula from an oxygen concentrator, The oxygen humidifier bottle and oxygen tubing were not labeled with a time or date. On 9/27/23 at 9:00 a.m., Resident 146's clinical record was reviewed. The physician orders included, but were not limited to: - Oxygen at 2 liters per nasal cannula, every shift, dated 9/14/23. - Change oxygen tubing and humidity, clean concentrator and filter, once a day on Sundays, dated 9/14/23. On 9/27/23 at 8:40 a.m., License Practical Nurse (LPN) 2, indicated she did not see a date on oxygen tubing for Resident 146 and Resident 148, but it was changed every Sunday. On 9/28/23 at 11:20 a.m., the Director of Nursing (DON) indicated the oxygen tubing should have		humidifier bottle and oxygen tubing. DNS/Designee will conduct rounds each day to ensure appropriate dating and labeling of oxygen humidifier bottle and oxygen tubing. If any deficient practice is identified, then the DON/designee will immediately label the time or date the humidifier bottle or oxygen tubing and will also in-service the nursing staff. **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 the labeling humidifier bottles and tubing audit tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to ensure all care plans are developed and in place until continued compliance is maintained for 2 consecutive quarters. 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 completed by October 19th, 2023.	

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	been labeled. On 9/28/23 at 10:20 a.m., the Director of Nursing, provided a copy of facilities Oxygen Therapy and Devices policy, undated, and indicated it was the currently used by the facility. A review of policy indicated, " ...Nasal Cannula, Change out weekly and PRN [as needed] ... Place in a labeled bag when not in use..." 3.1-47(a)(6)			