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	10/24/2023

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: 10/24/23 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 10/25/23	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 November 6th, 2023.**	
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: 10/24/23 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	11/06/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
	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 10/25/23		**desk review in lieu of annual survey review on or after November 6th, 2023.**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
	partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 11 hazardous areas such as a soiled linen rooms was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the Soiled Utility room near the Moving Forward nurse's station. Findings include: Based on observation with the Maintenance Director, Field Maintenance Supervisor and Executive Director during a tour of the facility from 1:13 p.m. to 2:30 p.m. on 10/24/23, the corridor	K 0321	**POC for tag 321** **SS-E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The corridor door to the soiled utility room across the hall from moving forward nurses' station and the soiled utility room doors are now both fixed.	11/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
	door to the soiled utility room across the hall from the Moving Forward nurse's station was equipped with a self-closing device but the door failed to latch into the door frame when tested three separate times. After swinging to close, the door did not positively latch into the frame. The soiled utility room contained a 55 gallon container full of soiled articles and a 45 gallon container partially full of articles. Based on interview at the time of observation, the Maintenance Director and Field Maintenance Supervisor confirmed the corridor door to the aforementioned hazardous area failed to latch into the door frame after self closing. This finding was reviewed with the Executive Director, Field Maintenance Supervisor and Maintenance Director at the exit conference. 3.1-19(b)		**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 doors were audited to ensure that all doors are latching appropriately with self-closing device. **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 all the doors are latched into the door frame with self-closing device. If any deficient practice is identified, then the Maintenance director/designee will immediately fix the door. **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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
			weeks, monthly for 6 months and then quarterly to ensure all the doors are latching into door frame with self-closing device. 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 November 6th, 2023.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
	the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 3 Baths in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 24 residents and staff in the 500 & 600 hall smoke compartment. Findings include: Based on observation with the Maintenance Director, Field Maintenance Supervisor and the Executive Director on 10/24/23 at 1:40 p.m., the Bath located near the 500 hall had a sprinkler head with an escutcheon not flush to the ceiling which exposed the attic space. There was another sprinkler head in the Bath that was missing an escutcheon and had a two inch by two inch square opening in the ceiling around the sprinkler, exposing the attic space. Based on interview at the time of observation, the Maintenance Director confirmed the two escutcheons were either missing or had fallen down from the ceiling, exposing the attic space. This finding was reviewed with the Executive Director, Field Maintenance Supervisor and Maintenance Director at the exit conference. 3.1-19(b)	K 0351	**POC for tag 351** **SS-E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The sprinkler head with escutcheon not flush to the ceiling when exposed the attic space and the other sprinkler head in bath which had the opening in the ceiling around the sprinkler will be fixed within 60 days. Services had been scheduled. **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 sprinkler heads were audited to ensure there is no opening in the celling around sprinkler heads. **What measures will be put into place and what systemic**	12/23/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
			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 no openings in the ceiling around the sprinkler head. If any deficient practice is identified, then the Maintenance director/designee will immediately fix the ceiling. **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 all the sprinkler heads with flush to the ceiling does not have any opening. 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 December 23, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation, record review and interview; the facility failed to ensure 1 of 16 portable fire extinguishers were given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect 22 residents, as well as staff in the Auguste Cottage smoke compartment. Findings include: Based on an observation with the Executive Director, Field Maintenance Supervisor and Maintenance Director on 10/24/23 at 1:47 p.m., the	K 0355	**POC for tag 355** **SS-E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The fire extinguisher missing from the annual testing inspection on the Auguste cottage is now inspected. **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 fire extinguishers had been audited for annual fire extinguisher testing. If any extinguisher is missing the annual inspection will be immediately inspected. **What measures will be put into**	11/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
	tag on the fire extinguisher in the lounge of Auguste Cottage had an annual inspection date of March 2022. Based on record review, the annual fire extinguisher testing occured on 03/16/2023 by the facility's contracted vendor. Based on interview at the time of observation, the Field Maintenance Supervisor stated that they were aware the fire extinguisher was inspected more than 12 months ago and had contacted the vendor to do annual maintenance. This finding was reviewed with the Executive Director, Field Maintenance Supervisor and Maintenance Director at the exit conference. 3.1-19(b)		**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 fire extinguisher is missing from the annual inspection. If any deficient practice is identified, then the Maintenance director/designee will immediately fix the problem. **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 no fire extinguisher in the facility is missing any annual inspection. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
			Deficiency will be completed by November 6th, 2023.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
	allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 110. Findings include: Based on observation with the Executive Director, Field Maintenance Supervisor and the Maintenance Director during a tour of the facility from 1:13 p.m. to 2:30 p.m. on 10/24/23, the latching mechanism on the corridor door to resident sleeping Room 110 failed to latch into the latching plate on the door frame when the door was tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door to Room 110 would not latch into the door frame to ensure the door would resist the passage of smoke. This finding was reviewed with the Executive Director, Field Maintenance Supervisor and the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	**POC for tag 363** **SS-E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The corridor door to the resident sleeping room 110 is now latching into the latching plate on the door frame is now fixed. **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 doors were audited to ensure that all doors are latching appropriately into the latching plate. **What measures will be put into place and what systemic**	11/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
			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 all the doors are latched into the door frame with latching plate. If any deficient practice is identified, then the Maintenance director/designee will immediately fix the door. **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 all the doors are latching into door frame with latching plate. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
			November 6th, 2023.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect at least 20 residents. Findings include: Based on observations made during a tour of the facility with the Executive Director, Field Maintenance Supervisor and Maintenance Director on 10/24/23 during a tour of the facility	K 0374	**POC for tag 374** **SS-E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The smoke barrier door nearest to the salon is now fixed and can fully latch and close. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	11/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
	from 1:13 p.m. to 2:30 p.m., the smoke barrier door set nearest to the Salon failed to fully close and latch after being tested on three separate occasions. Based on an interview at the time of the observation, the Field Maintenance Supervisor confirmed the barrier door set did not latch and he would look at the door set and fix the issue as soon as he was able to do so. This finding was reviewed with the Executive Director, Field Maintenance Supervisor, and the Maintenance Director at 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 doors were audited to ensure that all doors are latching and closing appropriately. **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 all the doors are latched and close. If any deficient practice is identified, then the Maintenance director/designee will immediately fix the door. **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 all the doors are latching and closing appropriately. The results of these audits will be reviewed by the committee overseen by the ED. If	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
			the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency will be completed by November 6th, 2023.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on all shifts for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Executive Director, Field	K 0712	**POC for tag 712** **SS-C** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Fire drills on second and third	11/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
	Maintenance Supervisor and Maintenance Director during record review from 10:23 a.m. to 1:13 p.m. on 10/24/23, second shift fire drills conducted on 02/28/23, 05/09/23, 09/25/23 and 12/29/22 were conducted at, respectively, 3:30 p.m., 3:10 p.m., 4:00 p.m. and 4:00 p.m. Additionally, third shift fire drills conducted on 03/29/23, 05/03/23, 09/06/23 and 11/15/22 were conducted at, respectfully, 6:00 a.m., 6:20 a.m., 4:34 a.m. and 6:00 a.m. Based on interview at the time of record review, the Executive Director and Field Maintenance Supervisor confirmed the aforementioned second and third shift fire drills were not conducted at unexpected times under varying conditions. This finding was reviewed with the Executive Director, Field Maintenance Supervisor and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		shifts are now conducted at unexpected times under varying conditions. **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 fire drills will be audited on a regular basis to ensure that the facility is doing fire drills at unexpected times under varying conditions. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** **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** biweekly for 4 weeks, monthly for 6 months and then quarterly to ensure that fire drills are held at unexpected times under varying conditions. The results of these audits will be reviewed by the committee overseen by the ED. If the threshold of 95% is not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
			achieved an action plan will be developed to ensure compliance. Deficiency will be completed by November 6th, 2023.	
K 0920 SS=B Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility	K 0920	**POC for tag 920**	11/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
	failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 20 residents and staff in Auguste Cottage smoke compartment. Findings include: Based on observation during a tour of the facility with the Executive Director, Field Maintenance Supervisor and Maintenance Director on 10/24/23 at 1:45 p.m., there was an extension cord in the nurse station area of Auguste Cottage that powered a computer and a small fan. Based on interview at the time of observation, the Field Maintenance Supervisor confirmed that a computer and fan was plugged into an extension cord, and removed the extension cord upon observation. The finding was reviewed with the Executive Director, Field Maintenance Supervisor and Maintenance Director during the exit conference. 3.1-19(b)		**SS-B** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The extension cord was immediately removed to ensure one of the one flexible cords were not used as substitute for fixed wiring. **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 will be audited on a regular basis to ensure that there is no flexible cords were used for a substitute for fixed wiring **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 no flexible cords used to substitute for fixed wiring. If any deficient practice is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 01 B. WING	10/24/2023

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
			identified, then the Maintenance director/designee will immediately fix the problem immediately. **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 there is no flexible cords are being used. 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 November 6th, 2023.	