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	11/07/2022

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 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/20/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/07/22 Facility Number: 000142 Provider Number: 155237 AIM Number: 100266940 At this PSR survey, Bethany Village was found not in compliance with Requirements 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 83 at the time of this visit. All areas where residents have customary access	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paige Metzler	Executive Director	11/28/2022

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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	were sprinklered and all areas providing facility services were sprinklered, except for one detached storage shed. Quality Review completed on 11/09/22			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 2 automatic sprinkler piping systems which failed a three-year trip test conducted pursuant to Section 13.4.4.2.2. of NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. NFPA 25, Section 14.3.1(3) states an obstruction investigation shall be conducted for system piping whenever foreign materials are in dry pipe valves or in check valves. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Facility requesting temporary waiver. Facility having 631 lineal feet of sprinkler pipe replaced prior to sprinkler flush. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	03/15/2023

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	material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 07/28/22 with the Director of Property Management, the Field Maintenance Supervisor, and the Maintenance Director during record review from 9:45 a.m. to 12:45 p.m. on 09/20/22, the facility's dry sprinkler system failed the three-year trip test conducted pursuant to Section 13.4.4.2.2. of NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition due to the presence of debris. The "Deficiency Summary" section of the 07/28/22 inspection report stated, "An obstruction investigation is recommended and due to finding debris in the system we recommend a system flush". Documentation supplied by the sprinkler system inspection contractor dated 08/31/22 indicated the dry sprinkler system was 3-year trip tested again and found it had been clogged with debris. Review of sprinkler system inspection contractor's "Sprinkler System Flush" proposal documentation dated 09/20/22 indicated "Upon reinspection on 09/15/22 it was noted that the test line clogged again and are calling for a full system flush". Based on interview at the time of record review, the Director of Property Management and the Field Maintenance Supervisor stated the three-year trip testing conducted 07/28/22, 08/31/22 and 09/15/22 showed debris was clogging the line and stated the facility was awaiting a flushing proposal from the sprinkler		**action(s) will be taken:** Facility has complete fire alarm detection/alarm system coverage. Facility is also a fully sprinkled facility. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Executive Director and/or Maintenance Supervisor will monitor the sprinkler system inspection, tests, and maintenance documentation to ensure continued compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** A contracted vendor will be complete the inspections and make recommendations as necessary. The Maintenance Supervisor/designee will report these recommendations to the Executive Director for further review and action as deemed appropriate. **By what date the systemic changes for each deficiency will be completed:** 3/15/2023	

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	inspection contractor which was received on 09/20/22 during the survey. Based on review of sprinkler system inspection contractor's "Purchase Agreement: Air Leak Investigation" documentation dated 10/17/22 with the Executive Director and the Maintenance Director during record review from 10:40 a.m. to 11:15 a.m. on 11/07/22, the inspection contractor highly recommends completing an air leak test on the dry sprinkler system before introducing water to sprinkler piping for the system flush. Based on review of the sprinkler system inspection contractor's "Purchase Agreement: Sprinkler Pipe Replacement" documentation dated 10/27/22, sprinkler piping air leaks were found from the recent air leak testing done and it was recommended to replace 631 feet of sprinkler piping before any sprinkler system flushing would be performed. The Executive Director provided an approved "Capital Expenditure Request" for the facility dated 10/28/22 for sprinkler pipe replacement at the time of record review. Based on interview at the time of record review, the Executive Director stated sprinkler system flushing has not yet been performed as the facility was awaiting sprinkler piping replacement prior to the system flush. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. This deficiency was cited on 09/20/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			

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K 0761 SS=E Bldg. 01	Based on record review, observation, and interview; the facility failed to ensure the proper operation was maintained for 2 of 2 rolling steel fire doors in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 2010 Edition, the Standard for Fire Doors and Other Opening Protectives, Section 11.4.1.1 requires an automatic-closing device shall be installed on every rolling steel door. Section 11.4.1.2 states rolling steel doors shall close automatically upon activation or release of a fusible link or detector. Section 11.4.2.2.1 states after the automatic closing is activated, the door shall remain in the closed position until the automatic-closing device has been reset. This deficient practice could affect over 20 residents, staff, and visitors in the Main Dining room. Findings include: Based on review of the rolling fire door inspection contractor's "Fire Door Drop Test" documentation dated 06/24/22 with the Director of Property Management, the Field Maintenance Supervisor, and the Maintenance Director during record review from 9:45 a.m. to 12:45 p.m. on 09/20/22, the rolling fire door in the kitchen and the rolling fire door in the dish room in the kitchen both failed annual testing conducted within the most recent twelve-month period. The "Deficiency Summary"	K 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** New roll up doors were installed on 11/11/2022. **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:** This alleged deficient practice has the potential to affect few residents, visitors, staff. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Executive Director or Maintenance Supervisor will monitor documentation of maintenance, inspection, and testing of fire door assemblies to ensure continued compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** A contracted vendor will be complete the inspections and make recommendations as necessary. The Maintenance Supervisor/designee will report these recommendations to the Executive Director for further	11/11/2022

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	section of the 06/24/22 report stated the kitchen rolling fire door passed visual inspection but failed testing. The "Deficiency Summary" section of the 06/24/22 report stated the dish room rolling fire door in the kitchen failed visual inspection and testing because "Parts are rusted-unable to test. Parts are so rusted it is not even capable of testing". Based on interview at the time of record review, the Director of Property Management and the Field Maintenance Supervisor stated rolling fire door repairs had not been completed and agreed rolling fire door repair documentation on or after 06/24/22 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 10:25 a.m. to 10:40 a.m. on 11/07/22, the rolling fire door inspection contractor had affixed a tag to the kitchen rolling fire door indicating the most recent inspection on the sticker was dated June 2020. The rolling fire door inspection contractor also affixed a tag to the dish room rolling fire door indicating the most recent inspection on the sticker was dated June 2019. Based on interview at the time of the observations, the Maintenance Director stated the rolling fire doors have not yet been repaired or replaced as the facility was awaiting parts from the rolling fire door inspection contractor. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. This deficiency was cited on 09/20/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		review and action as deemed appropriate. **By what date the systemic changes for each deficiency will be completed:** 11/11/2022	