STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHANY VILLAGE ASSISTED LIVING	3530 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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: March 20 and 21, 2024 Facility Number: 001121 Residential Census: 73 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed March 22, 2024.	R 0000		
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure potentially	R 0148	What corrective action(s) will be accomplished for those	04/19/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gary Griffin	Executive Director	04/09/2024

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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	hazardous materials were kept secure and behind locked doors to prevent resident's access to the materials for 2 of 2 random observations. (Biohazard door, Mechanical door) Findings include: 1. During the initial tour of the facility on 3/20/24 from 8:30 a.m. until 8:50 a.m., the biohazard door, located on the first floor near the elevator and across from the Clinical Director's office was observed. The door labeled biohazard was observed to not be closed. Inside the room a large red plastic container filled with used sharps material (syringes) was observed. No staff were visible in the room or in the immediate area. 2. During the initial tour of the facility on 3/20/24 at 10:07 a.m., a door labeled Mechanical on third floor next to an elevator and across from Room 317, was observed to be unlocked. Inside the room was a electrical panel and two large hot water heaters with water tubes hanging down. During an interview at that time, the DON indicated that all doors with potentially hazardous chemicals should be locked, "especially the biohazard door should be locked". On 3/20/24 at 11:59 a.m., the Clinical Support Nurse indicated, the facility did not have a policy on locked doors or locked biohazard doors and at that time.		residents found to have been affected by the deficient practice; **No residents were affected. The unlocked biohazard door on the first floor and the mechanical room on the third floor had automatic door lock changed on 4/3/23.** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **physical plant review completed on 3/20/24 by maintenance director to review all doors that require to be locked at all times and automatic doors locks ordered on 3/22/24.** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **A CQI tool for environmental safety and door locks was implemented on 3/25/24 for three consecutive weeks, followed by one week in each of the next two months.** 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 **A CQI tool for environmental safety and door locks was implemented on 3/25/24 for three consecutive weeks, followed by one week in each**	

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			of the next two months. If the threshold of 95% is not met the results will be reviewed at the monthly safety meeting and an action plan will be developed and or disciplinary action. The CQI tool will be overseen by the maintenance director and executive director/designee. By what date the systemic changes will be completed. **April 19, 2024**	