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	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Village	3518 S Shelby St Indianapolis, IN 46227

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 36746 Based on observation, interview, and record review, the facility failed to ensure reasonable accommodation of needs for 1 of 8 residents observed. A call light was not within reach. (Resident 86) Finding includes: On 9/10/24 at 1:45 p.m., observed Resident 86 in bed. Resident 86's call light was hanging over the bed and was on the floor next to the residents bed, out of the reach of the reach of the resident. During an interview at that time, the Assistant Director of Nursing (ADON) indicated the call light should have been within the reach of the resident. On 9/10/24 at 11:52 a.m., the DON provided a policy titled Resident [NAME] of Rights, dated 12/2017, and indicated it was the current policy being used by the facility. A review of the policy indicated, .(b. the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the community . 3.1-3(v)(1)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 38466 Based on interview and record review, the facility failed to ensure that written notification was provided to the Office of the State Long-Term Care Ombudsman for 1 of 4 residents reviewed for written transfer and discharge notification. (Resident 39) Finding includes: On 9/5/24 at 1:05 p.m., Resident 39's clinical record was reviewed. The diagnoses include, but were not limited to, delusional disorder, severe dementia with agitation, and mood disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 8/1/24, indicated Resident 39 was severely cognitively impaired. 1. The ASC (American Senior Communities) Hospital ER (emergency room /Department) Transfer Form, dated 3/18/24, indicated Resident 39 was transferred to the hospital Emergency Department on 3/18/24 at 8:06 a.m. The transfer was a facility-initiated transfer. 2. The ASC Hospital ER Transfer Form, dated 3/19/24, indicated Resident 39 was transferred to a psychiatric hospital on 3/19/24 at 2:30 p.m. The transfer was a facility-initiated transfer. 3. The ASC Hospital ER Transfer Form, dated 4/27/24, indicated Resident 39 was transferred to a psychiatric hospital on 4/27/24 at 7:40 p.m. The transfer was a facility-initiated transfer. 4. The ASC Hospital ER Transfer Form, dated 5/22/24, indicated Resident 39 was transferred to the ER and then transferred to a psychiatric facility on 5/22/24 at 2:30 p.m. The transfer was a facility-initiated transfer. The clinical record lacked documentation that the Office of the State Long-Term Care Ombudsman was notified, in writing, that Resident 39 had been transferred to another facility in March 2024, April 2024, and May 2024. During an interview on 9/10/24 at 12:31 p.m., the Social Service Director indicated Resident 39's transfer to the Emergency Department and to a psychiatric facility was a facility-initiated transfer. The Office of the State Long-Term Care Ombudsman had not been notified of Resident 39's facility-initiated transfers to another facility in March 2024, April 2024, and May 2024. During an interview on 9/10/24 at 1:00 p.m., the Administrator indicated the facility lacked a specific policy regarding the Office of the State Long-Term Care Ombudsman notification of a resident's facility-initiated transfer to another facility. 3.1-12(a)(6)(A)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45292 Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) assessment was completed for 2 of 4 residents reviewed for accuracy of MDS assessments. Falls were not coded correctly. (Resident 35, Resident 92) Findings include: 1. The clinical record of Resident 35 was reviewed on 9/5/24 at 1:45 p.m. The diagnoses included, but were not limited to, Parkinson's disease, unsteadiness on feet, repeated falls, generalized muscle weakness, syncope and collapse, and difficulty in walking not. A Fall Event, dated 7/9/24, indicated an unwitnessed fall. Resident 35 had left shoulder pain that required x-rays to rule out fracture. A Quarterly MDS assessment, dated 8/7/24, indicated Resident 35 had not had any falls since their prior MDS assessment, a Quarterly MDS assessment, dated for 5/10/24. During an interview on 9/9/24 at 10:50 a.m., the MDS Coordinator indicated the MDS assessment, dated 8/7/24, should have indicated Resident 35 had experienced falls. 2. The clinical record of Resident 92 was reviewed on 9/5/24 at 1:03 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, unspecified dementia, generalized muscle weakness, and age-related physical debility. A Fall Event, dated 7/7/24, indicated a witnessed fall where Resident 92 stood and fell close to a nursing station. A Fall Event, dated 7/13/24, indicated a witnessed fall where Resident 92 stood from her chair and fell . A Fall Event, dated 7/21/24, indicated an unwitnessed fall where Resident 92 was found by staff sitting on the floor of their room. A Significant Change MDS assessment, dated 7/22/24, indicated Resident 92 had not had any falls since their prior MDS assessment, a Significant Change assessment, dated for 5/19/24. During an interview on 9/9/24 at 9:46 a.m., the MDS Coordinator indicated the MDS assessment, dated 7/22/24, should have indicated Resident 92 had experienced falls. During an interview on 9/9/24 at 10:50 a.m., the MDS Coordinator indicated the facility followed RAI (Resident Assessment Instrument) guidelines for MDS assessments. 3.1-31(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 36746 Based on observation, interview, and record review, the facility failed to provide services to a resident with an ulcer on her right heel for 1 of 3 residents reviewed for pressure ulcers. (Resident 86) Finding includes: On 9/6/24 at 10:15 a.m., observed Resident 86's right heel to have an uncovered wound. The area was not wrapped with gauze (a protective covering). On 9/9/24 at 9:33 a.m., observed Resident 86's right heel. The wound on the right heel was observed to be uncovered. On 9/9/24 at 11:22 a.m., observed the wound on Resident 86's right heel to not be wrapped in gauze. On 9/10/24 at 10:30 a.m., the clinical record for Resident 86 was reviewed. The diagnosis, included but was not limited to, type II Diabetes Mellitus. A Quarterly Braden Score (a risk assessment tool that predicts the likelihood of developing pressure ulcers), dated 8/15/24 indicated Resident 86 had a very high risk for pressure ulcers. A Physicians Order, dated 8/27/24, indicated cleanse right heel with normal saline, pat dry, apply collagen to wound bed, cover with board gauze every three days. During an interview on 9/9/24 at 11:25 a.m., the Assistant Director of Nursing indicated the wound on Resident 86's heel should have been wrapped and was unsure why it was not wrapped during the observations. On 9/8/24 at 3:45 p.m., the Executive Director provided a policy titled Skin Management Program, dated 5/2022, and indicated it was the current policy being used by the facility. A review of the policy indicated Purpose: To promote the prevention of pressure ulcers/injury development; promote the healing of existing pressure ulcers and prevent development of additional pressure ulcer injury.4. preventative measures and treatments will be implemented as appropriate. 3.1-40(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38466 Based on observation, interview, and record review, the facility failed to ensure the facility was free from accident hazards for 1 of 1 observation, potentially affecting 36 of 56 self-mobile residents residing in the facility. A rubber hose used for fish tank maintenance was located on the floor in the middle of a walkway area that was used by the residents. (500 hall) Finding includes: During an observation, on 9/6/24 from 9:00 a.m. to 9:13 a.m., the following was observed on the 500-hall floor space between the resident pantry and the resident lounge area: - A dark colored rubber hose, approximately one inch in diameter and approximately 25 feet in length, was observed in the middle of the walkway that ran from the resident pantry room (on the left side of the hall) to the resident lounge (on the right side of the hall) of the 500-hall. - Approximately ten feet from the lounge area, the dark colored rubber hose was observed to be curled onto itself which raised the hose approximately two inches from the floor. - Approximately eight feet from the lounge area, the dark colored rubber hose was raised above the floor approximately three inches from the floor. - Multiple residents were observed watching television in the resident lounge. - No staff were visible in the area where the dark colored rubber hose was located. - No caution signs were visible in the hallway near where the dark colored rubber hose was located. On 9/6/24 at 9:14 a.m., LPN 2 was observed walking from the lounge area toward the nurse's station located across from the resident pantry room. During an interview at that time, LPN 2 indicated she was unsure if any caution signs should have been placed near the rubber hose to alert residents of a potential trip hazard. During an interview on 9/6/24 at 9:50 a.m., the Administrator indicated the rubber hose should not have been placed in the middle of the walkway on the 500-hall. The hallway was to be kept clear of any potential tripping hazards. Caution signs should have been in place to alert residents of a potential tripping hazard. On 9/6/24 at 1:44 p.m., the Director of Nursing Services provided a document that indicated there were 36 of 56 self-mobile (ability to move independently without staff assistance) residents who had access to the 500-hall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 9/6/24 at 2:16 p.m. the Administrator provided a copy of the American Senior Communities General Health and Safety Policies, dated 12/2023, and indicated it was the current policy in use by the facility. A review of the policy indicated, .all recognized safety and health hazards shall be eliminated or controlled as quickly as possible .must be kept free and clean of extraneous materials that could create a health hazard or cause an accident . 3.1-45(a)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 36746 Based on observation, record review, and interview, the facility failed to ensure a treatment cart was locked and secured for 1 of 1 random observations. (Memory Care Treatment Cart) Findings include: On 9/6/24 from 9:00 a.m. to 9:15 a.m., during medication administration pass observation, on the memory care unit, observed an unlocked treatment cart with no staff present in the area. Multiple residents were observed wandering around the unit. The treatment cart was easily opened. Inside the unlocked cart, the following medicated treatments, included but were not limited to: - Two tubes containing 30 grams of Nystatin Topical Cream (a medicated cream was used to treat fungal or yeast infections on your skin). The tube of medicated cream indicated .keep out of reach . - One tube containing one ounce of vagisil cream (anti-itch medication). The label on the tube of medicated cream indicated .keep out of reach . - One fourteen ounce jar of Aquaphor healing ointment. The label on the ointment indicated .keep out of reach . During an interview on 9/6/24 at 9:10 a.m., LPN 3 indicated the treatment cart should have been locked. During an interview on 9/6/24 at 9:39 a.m., the Executive Director indicated the treatment cart should have been locked. On 9/6/24 at 1:44 p.m., the DON provided a document that indicated there were 20 of 25 cognitively impaired self-mobile residents residing on the Memory Care Unit. On 9/6/24 at 9:52 a.m., the Director of Nursing provided a policy titled Storage and Expiration Dating of Medications and Biologicals, dated 8/1/24, a review of the policy indicated .5. Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. 3.1-25(m)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36746 Based on observation, record review, and interview, the facility failed to ensure a homelike atmosphere for 1 of 8 rooms observed for a homelike setting. Drywall was missing. (room [ROOM NUMBER], Resident 86) Finding included: During a tour of the facility on 9/4/24 at 10:30 a.m., observed a six inch by six inch hole in room [ROOM NUMBER]. The hole was in the drywall above the residents room light. The hole was observed to have exposed wires. During an interview at that time, the Resident 86 who resided in that room was unaware of how long the hole with exposed wires had been there. On 9/5/24 at 9:00: a.m., observed the same. On 9/6/24 at 10:30 a.m., observed the same. On 9/9/24 at 9:57 a.m., observed the same. During an interview on 9/9/24 at 10:01 a.m., the Executive Director indicated she was not aware of the hole in room [ROOM NUMBER]. The Executive Director indicated the facility did not currently have a maintenance director. 3.1-19(f)