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	09/08/2025

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 2 of 3 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Dietary Aide 7 and Dietary Aide 8) Findings include: 1. During a follow-up kitchen observation, on 9/2/25 from 11:35 a.m. to 11:40 a.m., the following was observed:- Dietary Aide 7 was observed walking through-out the kitchen service area where the noon meal was being prepared and near the steamtable that held the hot foods for the noon meal. Dietary Aide 7 was observed to have facial hair, approximately one-half inch in length, above and below the lip area and at the upper cheek bone area. The facial hair was observed to not be covered.- Dietary Aide 8 was observed walking through-out the kitchen service area where the noon meal was being prepared and near the steamtable that held the hot foods for the noon meal. Dietary Aide 8 was observed wearing a white hair net that covered hair from above the ears and approximately three inches above the neckline area to the top of the head. Below the white hair net, Dietary Aide 8 was observed to have multiple loose hairs approximately 12 to 18 inches in length. Multiple hairs were pulled from behind both ears and were observed resting on his chest area. Multiple hairs were observed hanging from the neckline to the mid shoulder area. The hairs were observed to not be covered.2. During a follow-up kitchen observation, on 9/2/25 from 12:33 p.m. to 12:45 p.m., the following was observed:- Dietary Aide 7 was observed walking through-out the kitchen service area where the noon meal was being plated and near the steamtable that held the hot foods for the noon meal. Dietary Aide 7 was observed to have facial hair, approximately one-half inch in length, above and below the lip area and at the upper cheek bone area. The facial hair was observed to not be covered.- Dietary Aide 8 was observed walking through-out the kitchen service area where the noon meal was being plated and worked at the steamtable that held the hot foods for the noon meal. Dietary Aide 8 was observed wearing a white hair net that covered hair from above the ears and approximately three inches above the neckline area to the top of the head. Below the white hair net, Dietary Aide 8 was observed to have multiple loose hairs approximately 12 to 18 inches in length. Multiple hairs were pulled from behind both ears and were observed resting on his chest area. Multiple hairs were observed hanging from the neckline to the mid shoulder area. The hairs were observed to not be covered.During an interview on 9/2/25 at 1:00 p.m., the Dietary Manager indicated staff's hair was to be kept covered while in the kitchen area. On 9/2/25 at 1:16 p.m., the Executive Director provided a copy of the Culinary Personal Hygiene policy, dated May 2025, and indicated it was the current policy in use by the facility. A review of the policy indicated, .All employees working in the culinary department must wear a clean hair restraint which effectively covers all hair .employees with facial hair, including beards and/or mustaches, must wear a beard restraint that effectively covers all facial all hair .On 9/2/25 at 3:30 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-26, effective April 16, 2025, indicated, .food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints .that are designed and worn to effectively keep their hair from contacting .exposed food .3.1-21(i)(2)3.1-21(i)(3)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure potentially hazardous materials were kept secured and behind locked doors to prevent resident's access to the materials potentially affecting 15 self-mobile cognitively impaired residents for 1 of 1 observation. (Housekeeping/Electrical room)Finding includes:On 9/4/25 from 11:00 a.m. to 11:08 a.m., the Housekeeping/Electrical room located near the main dining room and the 300 hall was observed. Posted on the door was a sign that indicated Not An Exit and a keypad lock was observed above the door handle. The door was observed to be open. Visible inside the room were multiple tools, electric wires, cleaning supplies, and various maintenance equipment. No staff were visible in the area during that time.On 9/4/25 at 11:09 a.m., Floor Technician 6 was observed walking from the nurse's station area and past three occupied resident rooms. Floor Technician 6 walked toward the Housekeeping/Electrical room and entered the open room. During an interview at that time, Floor Technician 6 indicated the Housekeeping/Electrical room door was to be kept closed and locked when no staff were in the area. On 9/5/25 at 9:40 a.m., during a facility tour with the Executive Director, the Housekeeping/Electrical room was observed. During an interview at that time, the Executive Director indicated the door was to be kept closed and locked when staff were not present.On 9/5/25 at 11:30 a.m., the Executive Director indicated there were 15 self-mobile cognitively impaired residents who could have accessed the unlocked Housekeeping/Electrical room.On 9/5/25 at 11:30 a.m., the Executive Director provided an undated copy of the Direct Supply Tels: Door's policy and indicated it was the current policy in use by the facility. A review of the document indicated, .doors to hazardous areas shall be self-closing or automatic closing . 3.1-45(a)

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, the facility failed to ensure dialysis medical records were shared between the facility and the dialysis center for 2 of 2 residents reviewed for dialysis. (Resident 2 and Resident 13) Finding includes:1.During an interview on 9/2/25 at 10:49 a.m., Resident 2 indicated he had been using dialysis services for years. He was transported to dialysis on Tuesday, Thursday, and Saturday. Resident 2 indicated he had not taken any facility paperwork to the dialysis center, nor did he return to the facility with any paperwork from the dialysis center.On 9/2/25 at 11:00 a.m., the clinical record for Resident 2 was reviewed. The diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis.The Quarterly Minimum Data Set (MDS) assessment, dated 8/11/25, indicated Resident 2 was cognitively intact and required dialysis services.During an interview on 9/4/25 at 10:55 a.m., Licensed Practical Nurse (LPN) 5 indicated Resident 2 was not sent with any facility paperwork and the resident did not return with any paperwork from the dialysis center.On 9/5/25 at 10:00 a.m., the Director of Nursing (DON) provided a copy of Resident 2's current physician orders which included, but were not limited to, Resident 2 was to be transferred to the dialysis center every Tuesday, Thursday, and Saturday for dialysis services, effective 2/19/25 with no end date noted. On 9/8/25 at 10:15 a.m., the DON provided a copy of Resident 2's August of 2025 - Appointment Administration History document. A review of the document indicated that staff documented that Resident 2 was transported to the dialysis center 13 times during the month of August of 2025. The document indicated Resident 2 received dialysis services every Tuesday, Thursday, and Saturday during the month of August.On 9/8/25 at 10:15 a.m., the DON provided a copy of Resident 2's September of 2025 - Appointment Administration History document. A review of the document indicated that staff documented that Resident 2 was transported to the dialysis center three times during the month of September of 2025. The document indicated Resident 2 received dialysis services on Tuesday, Thursday, and Saturday during the month of September.The clinical record lacked dialysis health related documentation that indicated communication between the facility and the dialysis center had been shared between the providers.2. On 9/4/25 at 12:44 p.m., the clinical record for Resident 13 was reviewed. The diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis.The admission MDS assessment, dated 6/4/25, indicated Resident 13 was cognitively intact and required dialysis services.During an interview on 9/5/25 at 8:20 a.m., Resident 13 indicated he was transported to dialysis on Tuesday, Thursday, and Saturday. Resident 13 indicated he had not been given any facility paperwork to be given to the dialysis center, nor had the dialysis center provided any paperwork to be returned to the facility.On 9/5/25 at 10:00 a.m., the DON provided a copy of Resident 13's current physician orders which included, but were not limited to, Resident 13 was to be transferred to the dialysis center every Tuesday, Thursday, and Saturday for dialysis services, effective 5/29/25 with no end date noted. On 9/8/25 at 10:15 a.m., the DON provided a copy of Resident 13's August of 2025 - Appointment Administration History document. A review of the document indicated that staff documented that Resident 13 was transported to the dialysis center 12 times during the month of August of 2025. The document indicated Resident 13 received dialysis services every Thursday and Saturday and three of four Tuesdays during the month of August.On 9/8/25 at 10:15 a.m., the DON provided a copy of Resident 13's September of 2025 - Appointment Administration History document. A review of the document indicated that staff documented that Resident 13 was transported to the dialysis center three times during the month of September of 2025. The document indicated Resident 13 received dialysis services on Tuesday, Thursday, and Saturday during the month of September.The clinical record lacked dialysis health related documentation that indicated communication between the facility and the dialysis center had been shared between the providers.During an interview on 9/5/25 at 9:45 a.m., the DON indicated the facility lacked any written communication between the facility and the dialysis center for Resident 2 and Resident 13. Nursing staff were to complete the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis communication binders, and it was supposed to be sent to dialysis with the residents. Then while at dialysis, the center was to update the communication binders and send them back with the residents. The binders were to be the communication vehicle to ensure both the facility and center were kept updated on the resident's health status. On 9/2/25 at 9:35 a.m., the Executive Director provided a copy of the Long-Term Care Facility Outpatient Dialysis Services Coordination Agreement, dated 8/23/21, and indicated it was the current dialysis agreement in use by the facility and dialysis provider. A review of the document indicated, .Mutual Obligations: Collaboration of Care.Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Long-Term Care Facility and [End Stage Renal Disease] Dialysis Unit. On 9/4/25 at 2:10 p.m., the DON provided a copy of the Dialysis Care policy, dated November 2017, and indicated it was the current policy in use by the facility. A review of the document indicated, .Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.The nurse in charge at time of transfer to dialysis will provide the resident with all appropriate paperwork.The nurse in charge at time of return will review paperwork for new orders and/or notes accompanying the resident.The facility will employ a method of communication between the facility and the dialysis center to rely changes in condition and response to treatment.3.1-37(a)

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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. Based on observation, interview, and record review, the facility failed to ensure insulin was labeled with an open date for 2 of 2 medication carts of observed. (Rehab Cart, Skilled Cart)Findings include: During an observation on 9/3/25 at 8:35 a.m., the rehab medication cart was observed. An opened and used insulin flex pen 100 units/ml was located in the medication cart. The pen lacked a label indicating the date it was opened. During an interview at that time, LPN 2 indicated there was no label on the insulin and indicated it should have been labeled at the time it was opened. During an observation on 9/3/25 at 8:45 a.m., the medication cart on the skilled unit was observed. An opened and used insulin flex Pen 100 units/ml was observed in the medicine cart. The flex pen lacked a label indicating when the pen was opened. The pen also lacked a label indicating to whom it was prescribed. During an interview at that time LPN 3 indicated the pen in medicine cart had been opened and should have been labeled. During an interview on 9/3/25 at 9:20 a.m., the Director of Nursing Services indicated the flex pens should have been dated at the time they were opened. On 9/3/25 at 9:27 a.m., the Executive Director provided a policy titled, American Senior Communities, Medication Storage and Expiration Policy, and indicated that the policy is the current policy being used by the facility. A review of the policy indicated 10. c, .If a multidose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. 3.1-25(j)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the current vaccine administration guidelines for both the influenza and pneumococcal vaccinations for 1 of 5 residents reviewed for vaccinations records. (Resident 10)Findings include:On 9/2/25 at 11:00 a.m., Resident 10's clinical record was reviewed and indicated the following:Resident 10's preventative health section in the electronic health record lacked records for any influenza or pneumococcal vaccinations. Resident 10's diagnoses included, but were not limited to, unspecified vascular dementia. Resident 10 had an admission date of 12/4/24 and was [AGE] years old or older.On 9/4/25 at 8:50 a.m., the DON (Director of Nursing) provided influenza and pneumococcal vaccination consent forms indicating Resident 10's guardian had consented for the resident to receive the recommended vaccinations for both influenza and pneumococcal vaccines. During an interview on 9/4/25 at 9:00 a.m., the DON indicated that there were not any records for Resident 10's influenza or pneumococcal vaccinations and that Resident 10 should have received them as recommended and requested with the guardian's signed consent. On 9/2/25, the ED (Executive Director) provided a policy titled Title: Influenza (Flu) Vaccination (Resident), reviewed 8/2021, and indicated it was the policy currently in use. The policy indicated that newly admitted residents who consented to receive the influenza vaccine during flu season, or while influenza was still actively circulating locally, should be offered and receive influenza vaccinations. On 9/2/25, the ED provided a policy titled Title: Pneumococcal Vaccination, reviewed 12/2024, and indicated it was the policy currently in use. The policy indicated that newly admitted residents who had consented to receive pneumococcal vaccinations would be offered and receive the appropriate PCV (pneumococcal conjugate vaccine) and/or the PPSV (pneumococcal polysaccharide vaccine) doses as indicated for each resident's criteria.On 9/5/25 at 9:30 a.m., a review of the CDC guidelines at the following website for influenza guidelines (https://www.cdc.gov/flu/hcp/acip/index.html), updated 8/28/25, indicated one dose annually of influenza vaccinations are recommended for all individuals 6 months of age or older, and that adults [AGE] years of age or older are particularly vulnerable to the influenza virus. On 9/5/25 at 9:45 a.m., a review of the CDC guidelines at the following website for pneumococcal guidelines (https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-notes.html#note-pneumo), updated 7/2/25, indicated that adults [AGE] years of age or older should have the recommended pneumococcal vaccinations, and for an individual over [AGE] years of age whose vaccination record is unknown, a dose of PCV 20 or PCV 21 is recommended. 3.1-13(a)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the current vaccine administration guidelines for Covid-19 vaccinations for 1 of 5 residents reviewed for vaccination records. (Resident 10)Finding includes:On 9/2/25 at 11:00 a.m., Resident 10's clinical record was reviewed and indicated the following:Resident 10's preventative health section in the electronic health record lacked records for any recent Covid-19 booster vaccinations; Resident 10 last had a historical vaccine on record in 2022 from a previous facility, but no subsequent vaccinations were administered. Resident 10's diagnoses included, but were not limited to, unspecified vascular dementia. Resident 10 had an admission date of 12/4/24 and was [AGE] years old or older.On 9/4/25 at 8:50 a.m., the DON (Director of Nursing) provided a Covid-19 vaccination consent form indicating Resident 10's guardian had consented for the resident to receive the recommend vaccinations and boosters for Covid-19. During an interview on 9/4/25 at 9:00 a.m., the DON indicated that Resident 10 should have received at least one booster dose of Covid-19 after being admitted to facility based on his immunization records. On 9/2/25, the ED (Executive Director) provided a policy titled Policy Title: Resident Covid-19 Vaccination, dated 12/2020, and indicated it was the policy currently in use. The policy indicated that upon admission, residents will be offered Covid-19 vaccinations based on their Covid-19 vaccination history and they should be offered and receive all additional doses and/or boosters to current consenting residents. On 9/5/25 at 9:30 a.m., a review of the CDC guidelines at the following website for Covid-19 guidelines (https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-age.html), updated 7/2/25, indicated that adults [AGE] years of age or older were to receive two of more doses of the 2024-2025 vaccination boosters. 3.1-13(a)