

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
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NAME OF PROVIDER OR SUPPLIER  BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/27/16</p> <p>Facility Number: 011045 Provider Number: 155698 AIM Number: 200380790</p> <p>At this Life Safety Code survey, Bethany Pointe Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original portion of the facility built in 1999, consists of everything except 600 wing and was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>The one story facility was determined to be Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in all</p>	K 0000	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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K 0021 SS=E Bldg. 01	<p>resident sleeping rooms. The facility has a capacity of 74 and had a census of 71 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review on 07/01/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview, the facility failed to ensure 2 of 2 doors leading into hazardous areas on 100 hall</p>	K 0021	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of	07/27/2016

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K 0029 Bldg. 01	<p>center such as the Kitchen and Laundry were not held open to prevent the door from closing. This deficient practice could affect 12 residents on 100 hall center as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 06/27/16 during the tour between 1:27 p.m. to 1:45 p.m. with the Maintenance Supervisor, the following hazardous area room doors located on 100 hall center, were held open with the following impediments which prevented the doors from closing:</p> <p>a. Kitchen door was held open using a stick of wood wedged between the self-closing device and the door jam.</p> <p>b. Laundry room door was held open using a stick of wood wedged between the self-closing device and the door jam.</p> <p>Based on interview on 06/27/16 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned hazardous area corridor doors were provided with impediments preventing closure of the doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour</p>		<p>Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <ol style="list-style-type: none"> <li>The alleged door impediments will be removed from the doors.</li> <li>The alleged deficiency had the potential to affect 12 residents on 100 hall.</li> <li>Director of Plant Operations will remove the alleged door impediments. DPO or designee to audit the facility for door impediments. DPO or designee to educate all departments regarding door impediments not being permitted.</li> <li>DPO or designee to audit the facility for door impediments weekly for 4 weeks, 2x per month for 8 weeks then monthly thereafter. Results will be forwarded monthly to the QAPI committee for review.</li> <li>To be completed by 7/27/16.</li> </ol>	

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	<p>fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors leading to hazardous areas on 100 hall center such as the Laundry would have doors which would latch into its frame. This deficiency could affect 12 residents on 100 hall center as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/27/16 at 1:35 p.m. with the Maintenance Supervisor, the Laundry door would contact with the door jamb preventing it from latching into its frame. Based on interview concurrent with the observation with the Maintenance Supervisor it was acknowledged the aforementioned hazardous area door would not latch into its frame.</p> <p>3.1-19(b)</p>	K 0029	<p>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <ol style="list-style-type: none"> <li>1. The facility to have the alleged door fixed in order to latch properly.</li> <li>2. The alleged deficiency had the potential to affect 12 residents on 100 hall.</li> <li>3. Executive Director or designee to educate Director of Plant Operations regarding self closing doors needing to latch properly. DPO or designee to audit all self closing doors in the facility to ensure they are latching properly.</li> <li>4. DPO or designee to audit self closing doors 2x month for 3 months then monthly thereafter. Results will be forwarded monthly to the QAPI committee for review.</li> <li>5. To be completed by 7/27/16.</li> </ol>	07/27/2016

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K 0050 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct fire drills on all shifts for 2 of 4 quarters for 2015. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill records on 06/27/16 at 3:45 p.m. with the Maintenance Supervisor, a fire drill report for the second shift of the fourth quarter of 2015 and the third shift of the third quarter of 2015 was not available for review. Based on interview on 06/27/16 at 3:47 p.m. with the Maintenance Supervisor, it was acknowledged the fire drills for the aforementioned shifts of the first and second quarters of 2015 could not be</p>	K 0050	<p>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <ol style="list-style-type: none"> <li>The facility cannot correct the alleged deficiency as it occurred in the past.</li> <li>The alleged deficiency had the potential to affect all residents in the facility.</li> <li>Executive Director or designee to educate Director of Plant Operations on proper procedure and timeframe for conducting fire drills.</li> <li>DPO or designee to audit to ensure facility is compliant with monthly fire drills. DPO or designee to audit weekly x4</li> </ol>	07/27/2016
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K 0130 SS=E Bldg. 01	<p>located.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, record review and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors were in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 12 residents on 600 hall center as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 06/27/16 at 1:45 p.m. with the Maintenance Supervisor,</p>	K 0130	<p>weeks, 2x month for 8 weeks then monthly thereafter. Results will be forwarded monthly to the QAPI committee for review. 5. To be completed by 7/27/16.</p> <p>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <ol style="list-style-type: none"> <li>The facility to receive an inspection on the alleged rolling fire door.</li> <li>The alleged deficiency had the potential to affect 12 residents on 600 hall.</li> <li>Executive Director or designee to educate Director of Plant Operations on the necessity of an annual inspection for all rolling fire doors. DPO or designee to audit all rolling fire doors to ensure inspections have been completed.</li> <li>DPO or designee to audit all rolling fire doors to ensure annual inspection is completed and not</li> </ol>	07/27/2016	

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K 0143 SS=E Bldg. 01	<p>there was one metal rolling fire door protecting the opening from the kitchen to the main dining room which was open to the corridor had an attached inspection tag dated 08/14/15. Based on review of the annual Rolling Metal Door inspection done on 06/27/16 at 3:35 p.m. with the Maintenance Supervisor, the report stated " the rolling metal door failed drop test. After release of the fusible link the door did not drop". Furthermore, the rolling metal door was open to the corridor via the dining room and was not designed to drop with the fire alarm. Based on interview concurrent with the observation with the Maintenance Supervisor the facility was aware the rolling metal door failed drop test, but did not know it had to drop with the fire alarm.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete</p>		<p>expired 2x month for 8 weeks then monthly thereafter. Results will be forwarded monthly to the QAPI committee for review. 5. To be completed by 7/27/16.</p>				

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	<p>flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs had continuously working, electrically powered mechanical ventilation. This deficient practice could affect 12 residents as well as visitors and staff on 100 hall center.</p> <p>Findings include:</p> <p>Based on observation on 06/27/16 at 1:40 p.m. with the Maintenance Supervisor, the oxygen storage room on 100 hall center used to store and transfer oxygen was provided with electrically powered mechanical ventilation, but it was not working. Based on interview concurrent with the observation, it was acknowledged by the Maintenance Supervisor, the oxygen room was used to transfer oxygen and the electrically powered mechanical vent was not working.</p> <p>3.1-19(b)</p>	K 0143	<p>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. The facility to correct the ventilation in the facility oxygen room. 2. The alleged deficiency had the potential to affect 12 residents on the 100 hall. 3. Executive Director or designee to educate Director of Plant Operations on electrically powered mechanical ventilation for the oxygen room. 4. DPO or designee to audit oxygen room ventilation to ensure proper functioning 5x week for 4 weeks, 3x week for 8 weeks, weekly for 8 weeks then monthly thereafter. Results will be forwarded monthly to the QAPI committee for review. 5. To be completed by 7/27/16.</p>	07/27/2016

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K 0000  Bldg. 02	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/27/16</p> <p>Facility Number: 011045 Provider Number: 155698 AIM Number: 200380790</p> <p>At this Life Safety Code survey, Bethany Pointe Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The 600 wing and was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The one story facility was determined to be Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 74 and had a census of 71 at</p>	K 0000	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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K 0050 SS=F Bldg. 02	<p>the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review on 07/01/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct fire drills on all shifts for 2 of 4 quarters for 2015. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill records on 06/27/16 at 3:45 p.m. with the</p>	K 0050	<p>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>1. The facility cannot correct the alleged deficiency as it occurred in the past.</p>	07/27/2016

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K 0070 SS=E Bldg. 02	<p>Maintenance Supervisor, a fire drill report for the second shift of the fourth quarter of 2015 and the third shift of the third quarter of 2015 was not available for review. Based on interview on 06/27/16 at 3:47 p.m. with the Maintenance Supervisor, it was acknowledged the fire drills for the aforementioned shifts of the first and second quarters of 2015 could not be located.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8</p> <p>Based on observation, interview and record review, the facility failed to regulate the use of 1 of 1 portable space heaters observed in non-resident rooms. This deficient practice could affect 8 residents on 600 wing as well as visitors and staff.</p> <p>Findings include:</p>	K 0070	<p>2. The alleged deficiency had the potential to affect all residents in the facility.</p> <p>3. Executive Director or designee to educate Director of Plant Operations on proper procedure and timeframe for conducting fire drills.</p> <p>4. DPO or designee to audit to ensure facility is compliant with monthly fire drills. DPO or designee to audit weekly x4 weeks, 2x month for 8 weeks then monthly thereafter. Results will be forwarded monthly to the QAPI committee for review.</p> <p>5. To be completed by 7/27/16.</p> <p>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>1. The alleged portable space heater will be removed.</p>	07/27/2016

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	<p>Based on observation on 06/27/16 at 2:15 p.m. with the Maintenance Supervisor, one portable space heater was plugged in and being used in the Business office on 600 hall. Based on interview on 06/27/16 concurrent with the observation, it was acknowledged by the Maintenance Supervisor the portable heater was allowed in non-resident rooms but was not aware the heating elements could not exceed 212 degrees Fahrenheit. The facility had a portable heater policy which verified this, but the facility could provide no documentation pertaining to the portable space heater available for review.</p> <p>3.1-19(b)</p>		<p>2. The alleged deficiency had the potential to affect 8 residents on 600 wing.</p> <p>3. Director of Plant Operations to educate all departments, including business office, on portable space heaters not being permitted. DPO or designee to audit facility for portable space heaters.</p> <p>4. DPO or designee to audit facility to ensure portable space heaters are not present weekly x4 weeks, 2x week for 8 weeks then monthly thereafter. Results will be forwarded monthly to the QAPI Committee.</p> <p>5. To be completed by 7/27/16.</p>		