

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 05/27/2015
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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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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: 05/27/15</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	<p>June 12, 2015</p> <p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the annual survey on May 27, 2015.</p> <p>Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p> <p>Nicole Fields, HFA Executive Director</p>	
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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 0052 SS=F 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>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, 1999 Edition, National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. NFPA 72, 3-8.1 allows fire alarm system components to share control equipment</p>	K 0052	<p>Bethany Pointe Health Campus</p> <p><u>K052</u></p> <p>Corrective action to be accomplished for those residents found to be affected by the alleged deficient practice:</p> <p>Koorsen was out to troubleshoot and diagnose the auxillary panel and noted that the audile noise seemed to be dampered and not functioning to expected levels. A new panel was ordered and will be installed upon</p>	06/26/2015

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	<p>or operate as stand alone systems, but in any case, they shall be arranged to function as a single system. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 05/27/15 at 3:20 p.m. with the Maintenance Supervisor, the primary phone line from the dialer was disconnected and after more than 200 seconds transpired a signal could be heard inside the mechanical room on Middle hall, but could not be heard outside the room and no signal or trouble light was observed anywhere else in the facility. Based on interview on 05/27/15 at 3:25 p.m. with the Maintenance Supervisor, it was acknowledged when the fire alarm system was placed into trouble with the primary phone line from the dialer disconnected, an audible or visual trouble signal could not be heard in an area where staff were likely to respond.</p> <p>3.1-19(b)</p>		<p>arrival.</p> <p>How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action will be taken:</p> <p>All residents residing in the Health Campus have the potential to be affected by the alleged deficient practice.</p> <p>Koorsen was out to troubleshoot and diagnose the auxillary panel and noted that the audile noise seemed to be dampered and not functioning to expected levels. A new panel was ordered and will be installed as soon as the part arrives.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Director of Plant Operations or designee will routinely check the fire panel for proper functioning. Any deficiencies noted will be addressed.</p>		

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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: 05/27/15</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</p>	K 0000	<p>How will the corrective action be monitored to ensure the alleged deficient practice does not recur:</p> <p>Audibility of the trouble alarm the auxiliary panel will be validated weekly times 4 weeks and monthly thereafter x 5 months to ensure compliance.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p>June 12, 2015</p> <p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to</p>	

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K 0104 SS=E Bldg. 02	<p>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 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>NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.</p>		<p>respond to the allegation of noncompliance cited during the annual survey on May 27, 2015.</p> <p>Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p> <p>Nicole Fields, HFA Executive Director Bethany Pointe Health Campus</p>	

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	<p>Based on observation and interview, the facility failed to ensure 1 of 5 smoke walls penetrated by ventilation ducts were provided with a smoke damper. LSC 101 section 8.3.5.1 states an approved damper designed to resist the passage of smoke shall be provided for each air transfer opening or duct penetration of a required smoke barrier. This deficient practice affect 17 residents on 100 hall, 17 residents on 600 hall as well as visitors and staff in the event of a fire emergency.</p> <p>Findings include:</p> <p>Based on observations on 05/27/15 at 2:07 p.m. with the Maintenance Supervisor, a smoke damper was not installed on the ventilation duct which penetrated the 600 hall smoke barrier wall. Based on interview on 05/27/15 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier wall which was penetrated by ventilating ductwork was not protected with an approved smoke damper.</p> <p>3.1-19(b)</p>	K 0104	<p><u>K104</u></p> <p>Corrective action to be accomplished for those residents found to be affected by the alleged deficient practice:</p> <p>Covert HVAC was onsite to evaluate compliance with area in question. A follow up appointment was scheduled to install a damper and connect it to the fire panel.</p> <p>How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action will be taken:</p> <p>Residents residing on the 100 and 600 hall have the potential to be affected by the alleged deficient practice.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Director of Plant Operations or designee will routinely check fire panel for proper functioning of the damper. Any deficiencies noted will be addressed.</p>	06/26/2015

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			<p>How will the corrective action be monitored to ensure the alleged deficient practice does not recur:</p> <p>Trouble alarms will be validated via fire panel checks weekly times 4 weeks and monthly thereafter times 5 months to ensure compliance.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		