

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155546	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BETHEL POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 W COMMUNITY DR MUNCIE, IN 47304
--	--

(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
F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00204859.</p> <p>Complaint IN00204859 - Substantiated. Federal/State deficiency related to the allegation is cited at F323.</p> <p>Survey dates: July 19 and 20, 2016</p> <p>Facility number: 000565 Provider number: 155546 AIM number: 100267630</p> <p>Census bed type: SNF: 12 SNF/NF: 76 Total: 88</p> <p>Census payor type: Medicare: 12 Medicaid: 59 Other: 17 Total: 88</p> <p>Sample: 4</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on July 21,</p>	F 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 the requirements established by State and Federal law. This facility respectfully requests paper compliance for the deficiencies cited.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155546	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BETHEL POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 W COMMUNITY DR MUNCIE, IN 47304
--	--

(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
F 0323 SS=D Bldg. 00	<p>2016.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure residents who were transferred using a mechanical lift were transferred with sufficient staff assistance to prevent accident and injury for 1 of 2 residents reviewed for transfers (Resident B).</p> <p>Findings include:</p> <p>The clinical record of Resident B was reviewed on 7/19/16 at 1:30 p.m. Diagnoses for the resident included, but were not limited to, heart failure, hypertension, Alzheimer's disease, dementia, anxiety and depression.</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment, dated 6/17/16, indicated Resident B was severely cognitively impaired. Resident B received the following Activities of Daily Living (ADL) assistance;</p>	F 0323	<p>CNA #1 immediately notified DON of completing mechanical lift transfer with 1 staff member on Resident B. DON immediately counseled CNA #1. CNA #1 received 1:1 education per review of facility</p> <p>Transfer/Positioning/Total Mechanical Lift Policy. CNA #1 completed return demonstration on the correct procedure for mechanical lift transfer. All other residents who are transferred per mechanical lift have the potential to be affected. An audit was completed to identify all residents requiring a mechanical lift transfer. A shift-to-shift in-service was placed for nursing staff on facility</p> <p>Transfer/Positioning Total Lift Policy. A nursing staff in-service is scheduled on August 9, 2016 to review mechanical lift transfers and Transfer/Positioning/Total Mechanical Lift Policy. DON/Designee completed mechanical lift skill performance checks with nursing staff.</p>	08/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155546	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BETHEL POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 W COMMUNITY DR MUNCIE, IN 47304
--	--

(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
	<p>transfer-extensive assist with two person assist, dressing, bathing, eating and hygiene-extensive assist with two person assist.</p> <p>During an observation on 7/20/16 at 9:15 a.m., upon entering the room, Resident B was observed up in a hoyer sling, slightly elevated above her bed. CNA #1 was observed to be transferring Resident B by herself. She had already started to move Resident B over her chair then lowered her into her geri-chair.</p> <p>During an interview on 7/20/16 at 11:11 a.m., CNA #1 indicated she usually had two people for a hoyer transfer. She indicated she was not thinking, just trying to get her work done. She indicated she knew it was a two person transfer.</p> <p>A health care plan problem, initiated 6/23/16, indicated "I need assistance with my ADLS related to dementia, limited range of motion, activity intolerance." Intervention included, but were not limited to, "I need a total mechanical lift and staff assistance for transfers...2 staff for transfers."</p> <p>Review of a physician's order, indicated "I have reviewed and concur with the Plan of Care" The order was signed 7/9/16.</p>		<p>DON/Designee will audit 12 nursing staff members perform mechanical lift transfers at various times on various shifts. These audits to be completed weekly X2, then monthly X2, then quarterly X3, to ensure sufficient staff assistance was provided. Results of these audits will be forwarded to QA for review monthly X3 then quarterly.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155546	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BETHEL POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 W COMMUNITY DR MUNCIE, IN 47304
--	--

(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
	<p>Review of a facility policy revised 6/12, titled "TRANSFER/POSITIONING TOTAL MECHANICAL LIFT" was provided by the DON on 7/20/16 at 11:14 a.m. It indicated the following:</p> <p>"Purpose: To provide guidelines in a safe transfer of the resident using a sling/maxi lift. General Guidelines: ...5. The lift will be completed with two staff."</p> <p>Review of a "Patient Handling Policy LIMITED LIFT" in-service, provided by the DON on 7/20/16 at 1:15 p.m., indicated the following:</p> <p>"...This policy is to be followed at all times. Failure to adhere to the policy will result in disciplinary action...."</p> <p>CNA #1 signed the form on 4/3/15.</p> <p>This Federal tag relates to Complaint IN00204859.</p> <p>3.1-45(a)(2)</p>			