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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155546 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/13/2012 |
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| NAME OF PROVIDER OR SUPPLIER BETHEL POINTE HEALTH AND REHAB | STREET ADDRESS, CITY, STATE, ZIP CODE 3400 W COMMUNITY DR MUNCIE, IN 47304 |
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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 |
|--------------------|---|---------------|--|----------------------|
| K0000 | <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: 12/13/12</p> <p>Facility Number: 000565 Provider Number: 155546 AIM Number: 100267630</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Bethel Pointe Health and Rehab 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) 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</p> | K0000 | 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. | |

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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| | <p>capacity of 101 and had a census of 82 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 by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/21/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | | |

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| K0051 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm activations would automatically transmit a signal to a central monitoring station. LSC 9.6.4 requires the fire alarm system shall be arranged to automatically transmit the fire alarm signal to an Auxiliary alarm system, Central station, Proprietary system or Remote station connection. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include: Based on observation on 12/13/12 at 3:15</p> | K0051 | <p>1. No residents, staff, or visitors were found to be affected. SafeCare Corporation of Indiana did receive signals during the time the FACP was illuminating a red supervisory trouble signal. The fire alarm system was working correctly during this time as well. Incorrect information was given to the surveyor regarding this by the Maintenance Director. 2. All residents, staff, and visitors have the potential to be affected. 3. The Maintenance Supervisor will continue to monitor the fire alarm system weekly to assure it is functioning per regulation. The Maintenance Supervisor will document his audits will be</p> | 01/12/2013 | | | |

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| | <p>p.m. with the Maintenance Supervisor, the Fire Alarm Control Panel (FACP) located in the central nurse's station was illuminating a red supervisory trouble signal indicating phone line trouble. At 3:17 p.m. the FACP was activated by the Maintenance Supervisor and the phone line transmission was received by the facilities monitoring company. Based on interview on 12/13/12 at 3:20 p.m. it was acknowledged by the Maintenance Supervisor, it was unexpected the monitoring company would receive the signal. He stated during previous tests the transmission was not received by the monitoring company and the trouble light indicating phone line trouble has been on for two days.</p> <p>3.1-19(b)</p> | | <p>documented on the TELS, preventive Maintenance internal checking system weekly. 4.Results of the audits will be presented to the QA Committee monthly times six (6) months to ensure compliance.5. Compliance Date: January 12, 2013.</p> | | |