STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155546		01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL POINTE HEALTH AND REHAB	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	This visit was for a Recertification and State Licensure Survey. Survey dates: January 13, 14, 15, 19, 20, 21, 2016 Facility number: 000565 Provider number: 155546 AIM number: 100267630 Census bed type: SNF: 14 SNF/NF: 81 Total: 95 Census payor type: Medicare: 15 Medicaid: 59 Other: 21 Total: 95 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on January 25, 2015.	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 defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurate in regards to hospice services (Resident #101) and physician orders for 2 of 21 residents reviewed for complete and accurate clinical records (Resident #96). Findings include: 1. The clinical record for Resident #101 was reviewed on 1/19/16 at 2:00 p.m. Diagnoses for Resident #101 included, but were not limited to, acute renal failure, dementia, and hypertension. The Interdisciplinary Team plan of care in Resident #101's hospice binder, dated 12/23/15, indicated the frequency of the	F 0514	1. Resident #101's hospice aide care plan progress notes were immediately retrieved and placed in the Hospice binder. The physician was immediately notified and a dialysis order was obtained for Resident #96. 2. An audit was completed on all hospice charts to ensure resident's clinical records were complete and accurate. An audit was completed of all dialysis residents' physician orders to ensure resident's clinical records were complete and accurate. 3. The hospice aide responsible for not turning in her hospice aide care plan progress notes timely, no longer is employed by the hospice company. The Administrator immediately notified the hospice director of lacking documentation. Hospice provided an in-service on facility required documentation to their staff	02/05/2016

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	Home Health Aide (HHA) visits was three times a week. The hospice binder for Resident #101 lacked HHA visits, titled "Hospice Aide Care Plan/Progress Note", for December 2015 to January 19, 2016, for 12/24/15, 12/28/15, 12/30/15, 12/31/15, 1/5/16, 1/6/16, and 1/7/16. During an interview with the Hospice Case Manager on 1/19/16 at 2:44 p.m., she indicated the hospice staff document their visit the same day as their visit. The "Hospice Aide Care Plan/Progress Note" was then placed in the resident's hospice binder. During an interview with the RN Consultant and the Director of Nursing (DON) on 1/20/16 at 1:45 p.m., the RN Consultant indicated the hospice binder for Resident #101 was now up to date. The "Hospice Aide Care Plan/Progress Note" for Resident #101 dated 12/24/15, 12/28/15, 12/30/15, 12/31/15, 1/5/16, 1/6/16, and 1/7/16, had been faxed from the hospice office. The DON indicated they requested the Hospice Case Manager complete audits of the hospice binders to ensure the documentation in the hospice binders was correct and current. During an interview with the Hospice		members. All visiting hospice aides will be responsible to check in at the center hall nurses station upon the start of their visit. All visiting hospice aides will be responsible to turn in their care plan progress notes immediately upon completion of their visits to the nurse at the central nursing station. IDT team will audit hospice aide care plan progress notes daily during am meeting to exclude weekends and holidays. An administrative nurse from the hospice company will audit hospice charts monthly to ensure records are complete and accurate. Results from this audit will be given to the Administrator. IDT team will audit physician orders for completeness upon admission and re-admission daily during am meeting to exclude holidays and weekends to ensure all residents receiving dialysis have a dialysis order in place. 4. Results of these audits will be forwarded to QA for review monthly X3 then quarterly.	

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	Case Manger on 1/20/16 at 2:01 p.m., she indicated the HHAs make copies of their visit documentation in the facility. They placed one copy of the visit note in the resident's hospice binder and one copy went to the hospice office. She indicated Resident #101's visit documentation had been at the hospice office only. She indicated she tried to spot missing documentation in the hospice binders. Review of the current, 6/2015, "HOSPICE SERVICES AGREEMENT", provided by the RN Consultant on 1/20/16 at 3:13 p.m., included, but was not limited to, the following: "...1.4 Information/Documentation provided to Facility on admission of Hospice Patient for non-Inpatient Hospices Services and on-going: ...[f] Copies of clinical notes after each visit...." 2. The clinical record for Resident #96 was reviewed on 1/19/16 at 9:50 a.m. Diagnoses for Resident #96 included, but were not limited to, end stage renal disease, diabetes, and hypertension. The current, signed physician orders for Resident #96 lacked an order for dialysis. The order for dialysis on Mondays,			

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	Wednesdays and Fridays had been discontinued on 12/15/15. During an interview with Resident #96 on 1/19/16 at 11:15 a.m., she indicated she went to dialysis on Mondays, Wednesdays and Fridays. During an interview with the Director of Nursing on 1/21/16 at 9:10 a.m., she indicated the order for dialysis for Resident #96 had been discontinued when she went to the hospital and had not been restarted/initiated when she returned from the hospital. 3.1-50(a)(1)			