STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155546		03/10/2016

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
K 0000 Bldg. 01	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). Survey Date: 03/10/16 Facility Number: 000565 Provider Number: 155546 AIM Number: 100267630 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. 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 capacity of 101 and had a census of 93 at the time of this survey.	K 0000	All deficiencies found on 3/10/2016 Life Safety Survey noted on the 2567 have been corrected as of 3/23/16. Facility requesting paper compliance at this time.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155546		03/10/2016

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
	All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one garage used for facility storage which was not sprinklered. Quality Review completed on 03/16/16 - DA			
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 16	K 0038	Four digit exit code was placed appropriately for emergency exit access on exit door by room 43. Measures have been taken to educate staff that door exit codes are not to be removed. Maintenance is to confirm weekly that door exit codes are properly placed at every locked door. Maintenance has added the weekly door exit code check to their weekly TELS preventative maintenance program. The facility administrator will monitor the report annually. This will ensure the code will remain on the locked exit door indefinitely.	03/11/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155546		03/10/2016

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
	residents, staff and visitors. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:35 a.m. to 1:30 p.m. on 03/10/16, the exit door by Room 43 was marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Maintenance Supervisor stated residents who have a clinical diagnosis to be in a secure building reside in the Alzheimer's Wing in Rooms 1 through 9 and acknowledged the four digit code was not posted at the exit door by Room 43. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code. 3.1-19(b)			
K 0067 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the			

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 03/10/2016

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
	manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 fireplaces were not used in 1 of 5 resident smoke compartment sleeping areas. Exception No. 2 to LSC 19.5.2.2 states fireplaces shall be permitted and used only in areas other than resident sleeping areas, provided that such areas are separated from resident sleeping spaces by construction having not less than a 1-hour fire resistance rating and that such fireplaces comply with the provisions of LSC 9.2.2. In addition, the fireplace shall be equipped with a fireplace enclosure guaranteed against breakage up to a temperature of 650 degrees Fahrenheit and constructed of heat-tempered glass or other approved material. If, in the opinion of the authority having jurisdiction, special hazards are present, a lock on the enclosure and other safety precautions shall be permitted to be required. This deficient practice could affect eight residents in the smoke compartment containing the natural gas fireplace in the main entrance lobby. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:35 a.m. to 1:30 p.m.	K 0067	Fire place no longer in service at this time and has been permanently shut off. Measures taken include having maintenance disconnect and cap supply line so no one is able to turn the fireplace on. Staff has been educated that we are no longer to have the fireplace in service. Maintenance will monitor the fireplace disconnect valve monthly to ensure that it is still disconnected and not able to be turned on by anyone. The monthly monitoring of the fireplace disconnect valve will be documented on paper for no less than 12 consecutive deficiency free months. The facility administrator will monitor the reports annually.	03/11/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155546		03/10/2016

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
	on 03/10/16, resident sleeping Rooms 18, 19, 20, 22, 23, 24, 25 and 26 are located in the same smoke compartment as the natural gas fireplace located in the main entrance lobby. The fireplace was operable and in use at the time of the survey. The front cover of the fireplace consisted of two glass doors which were each in the fully open position. Each of the aforementioned resident room corridor doors had a 20 minute fire resistance rating label affixed to the door. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged resident sleeping Rooms 18, 19, 20, 22, 23, 24, 25 and 26 are located in the same smoke compartment as the natural gas fireplace located in the main entrance lobby and the front cover of the fireplace was not constructed of heat-tempered glass or other approved material. 3.1-19(b)			
K 0072 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct			

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 03/10/2016

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
	exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use for 1 of 8 exits means of egress. This deficient practice could affect 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:35 a.m. to 1:30 p.m. on 03/10/16, two separate employee locker stands were stored in the service corridor which was marked as a facility exit with an exit sign. Each of the locker stands projected twelve inches into the corridor. Based on interview at the time of the observations, the Maintenance Supervisor stated the employee lockers have always been stored in the service corridor and acknowledged corridor storage in the means of egress for the service corridor exit was not continuously maintained free of all obstructions or impediments to full instant use. 3.1-19(b)	K 0072	Employee lockers removed from the service corridor and placed in the employee break room. Measures taken to make sure that the corridors are free of all obstructions include educating staff that the exit corridors must remain free of obstructions at all times. Measures also include adding the weekly monitoring of exit corridors in TELS preventative maintenance program to ensure they are free of obscurities. The facility administrator will monitor reports annually.	03/23/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155546		03/10/2016

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