

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 07/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(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
K010000	<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: 07/10/13</p> <p>Facility Number: 011045 Provider Number: 155698 AIM Number: 200380790</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</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 except for overhang outside the north exit of the Assisted living hall.</p>	K010000	<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 on 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 July 10th, 2013. Please accept this plan of correction as the provider's credible allegation of compliance.</p>	

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: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(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 the evacuation routes indicate the Healthcare residents are allowed complete access to the entire facility and its exits which would include the Assisted Living hall. 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 62 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered except for the exit canopy outside the Assisted Living north hall. All areas providing facility services were sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/15/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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 07/10/2013	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012			
(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			
K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 2 sets of double leaf corridor doors could latch into their door frames. This deficient practice could affect 2 residents observed in the Therapy room and 10 residents on North hall in Assisted Living as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 07/10/13 during the tour between 12:15 p.m. and 4:00 p.m., the following double door sets required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame:</p>	K010018	<p>K 018Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</p> <p>The 2 sets of the four sets of double leaf corridor doors leading into 600 dining room have roller latches which do not latch into their door frames. The 2 sets of the four sets of double leaf corridor doors leading into 600 dining room have no latches. The facility will install spring loaded latches which latch into the door frames of all four sets of doors. The facility will install two lock sets for the double leaf corridor doors which do not have handles. The facility will install spring loaded hinges to the 2 sets of doors which do not have spring loaded hinges.</p> <p>Identification of other residents</p>	08/09/2013			

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 07/10/2013
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		
(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>a. The double leaf corridor doors leading into Therapy on Service hall.</p> <p>b. The double leaf corridor doors leading into Activities on North hall, Assisted Living.</p> <p>Based on interview on 07/10/13 concurrent with the observations, it was acknowledged by the Maintenance Supervisor, each of the aforementioned corridor doors would not latch independently into the door frame.</p> <p>3.1-19(b)</p>		<p>having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents who eat in the 600 dining room could have the potential to be affected by this action. The facility will install spring loaded latches which latch into the door frames of all four sets of doors. The facility will install two lock sets for the double leaf corridor doors which do not have handles. The facility will install spring loaded hinges to the 2 sets of doors which do not have spring loaded hinges.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DPO or designee will monitor/audit new door new spring loaded latches, closures, and lock set to ensure proper mechanical working of the doors weekly times 4 weeks, then monthly times 5 months. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee and Safety Committee monthly for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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 07/10/2013	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012			
(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			
K010051 SS=E	<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 3 of 169 smoke detectors were installed in a location which would allow the smoke detector to function to its fullest capability. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 22 residents on West hall, and 9 residents on Assisted Living west hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 07/10/13 during</p>	K010051	<p>K 051 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</p> <p>The smoke detector in the 600 Clean Utility room was one foot from a ceiling supply vent located where air flow may have prevented the operation of the detector. The facility moved the smoke detector on July 23, 2013 to a location, at least three feet, which would allow the smoke detector to function to its fullest capability.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and</p>	08/09/2013			

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 07/10/2013
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		
(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>the tour from 12:05 p.m. to 3:00 p.m. with the Maintenance Supervisor, the following smoke detectors were all within two feet from an air diffuser in the ceiling:</p> <p>a. The smoke detector in the Laundry room on Service hall was ten inches from a ceiling supply vent.</p> <p>b. The two smoke detectors on Assisted Living east hall were one and one half feet from ceiling supply vents.</p> <p>Based on interview on 07/10/13 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned smoke detectors were installed within two feet of an air supply duct in the ceiling which would interfere with the smoke detector's ability to detect smoke to its fullest capability.</p> <p>3.1-19(b)</p>		<p>corrective actions taken: In the event of a fire, all residents within the vicinity of the 600 Clean Utility room could have the potential to be affected by this action. The facility moved the smoke detector on July 23, 2013 to a location, at least three feet, which would allow the smoke detector to function to its fullest capability.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DPO or designee will monitor/audit new locations of the smoke detectors to ensure proper mechanical working weekly times 4 weeks, then monthly times 5 months. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee and Safety Committee monthly for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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 07/10/2013	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012			
(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			
K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 3 exits with an outside canopy in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior combustible roofs or canopies exceeding four feet in width. This deficient practice could affect 12 residents on Assisted Living north hall as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 at 2:35 p.m. with the Maintenance Supervisor,</p>	K010056	<p>K 056Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The facility did not install a complete automatic sprinkler system to the north east Assisted Living exit with an outside canopy. The facility installed a complete sprinkler system with two heads to the north east Assisted Living outside canopy exit on July 24, 2013. The facility had a sprinkler heads in the Therapy room which was spaced less than the minimum of 6 feet apart from the other sprinkler heads. On July 24, 2013, the facility remove this sprinkler head which resulted in the sprinkler heads being at a minimum of not less than 6 feet apart in the Therapy room.Identification of other residents having the potential</p>	08/09/2013			

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 07/10/2013	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012			
(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>the canopy outside the Assisted Living north hall exit was attached to the building and extended ten feet from the building and was constructed of wood with a vinyl ceiling and asphalt shingles for a roof. Based on interview on 07/10/13 at 2:37 p.m. with the Maintenance Supervisor, it was acknowledged there was no sprinkler head present for the canopy outside the Assisted Living north hall exit to provide complete sprinkler coverage for the facility.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads were spaced a minimum of 6 feet apart for 1 of 1 automatic sprinkler systems. NFPA 13, Section 5-6.3.4, " Minimum Distance between Sprinklers ", states sprinklers shall be spaced not less than 6 feet on center. In addition, LSC 19.1.1.4.5 requires minor renovations, alterations, modernizations, or repairs shall not reduce life safety below the level that previously existed. This deficient practice could affect 20 residents on West hall as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 at 1:40</p>		<p>to be affected by the same alleged deficient practice and corrective actions taken: In the event of a fire, all residents who are in the vicinity of the north east outside canopy of the Assisted Living exit and in the vicinity of the Therapy room could have the potential to be affected by these actions. On July 24, 2013, the facility installed a complete sprinkler system with two heads to the north east Assisted Living outside canopy exit and the facility remove the sprinkler head in the Therapy room which resulted in the sprinkler heads in the Therapy room being at a minimum of not less than 6 feet apart in the Therapy room. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DPO or designee will monitor/audit the new complete sprinkler system and the removal of the sprinkler head in therapy to ensure proper mechanical working of the facility's sprinkler system weekly times 4 weeks, then monthly times 5 months. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee and Safety Committee monthly for a minimum of 6 months then</p>				

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 07/10/2013
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		
(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.m. with the Maintenance Supervisor, the Therapy room on Service hall adjacent to West hall had two ceiling sprinkler heads which were measured to be three feet apart located in the middle of the room. Based on interview on 07/10/13 at 1:44 p.m. with the Maintenance Supervisor, it was acknowledged the two sprinkler heads observed were less than six feet apart. 3.1-19(b)		randomly thereafter for further recommendation.		

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 07/10/2013	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012			
(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			
K010062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure 2 of 2 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Systems report on 07/10/13 at 3:31 p.m. with the Maintenance Supervisor, the facility lacked documentation of annual inspections for one private fire hydrant next to the front entrance walkway. Based on interview concurrent with record review with the Maintenance Supervisor, it was confirmed documentation of an annual fire hydrant</p>	K010062	<p>K 062Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The facility's two private fire hydrants were not inspected and tested periodically. On July 24, 2013, the facility had the two fire hydrants inspected and put an annual inspection schedule of the facility's fire/sprinkler company.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: In the event of a fire, all residents could have the potential to be affected by this action. On July 24, 2013, the facility had the two fire hydrants inspected and put an annual inspection schedule of the facility's fire/sprinkler company.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The facility had the two fire hydrants inspected on July 24, 2013 and put an annual inspection schedule of the facility's fire/sprinkler company. How the corrective measures will be</p>	08/09/2013			

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 07/10/2013
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		
(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	
	inspection was not available for review. 3.1-19(b)		monitored to ensure the alleged deficient practice does not recur: The results of the monitor/ audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee and Safety Committee after the first inspection and then randomly thereafter for further recommendation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2013	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012			
(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
K020000	<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: 07/10/13</p> <p>Facility Number: 011045 Provider Number: 155698 AIM Number: 200380790</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</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 600 wing was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The one story facility was determined to be Type V (111) construction and fully sprinklered except for overhang outside the north exit of the Assisted living hall. Review of the evacuation routes indicate the Healthcare residents are allowed</p>			K020000	<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 on 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 July 10th, 2013. Please accept this plan of correction as the provider's credible allegation of compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2013
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		
(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>complete access to the entire facility and its exits which would include the Assisted Living hall. 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 62 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered except for the exit canopy outside the Assisted Living north hall. All areas providing facility services were sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/15/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2013
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		
(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	
K020018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 sets of double leaf corridor doors could latch into their door frames. This deficient practice could affect 12 residents on 600 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 07/10/13 during the tour between 12:15 p.m. and 4:00 p.m., the following double door set required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame:</p> <p>a. The four double leaf sets of corridor doors leading into the Dining room on 600 hall.</p> <p>Based on interview on 07/10/13 concurrent with the observations, it was acknowledged by the Maintenance Supervisor, each of the aforementioned set of corridor doors would not latch independently into the door frame.</p>	K020018	<p>K 018Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</p> <p>The 2 sets of the four sets of double leaf corridor doors leading into 600 dining room have roller latches which do not latch into their door frames. The 2 sets of the four sets of double leaf corridor doors leading into 600 dining room have no latches. The facility will install spring loaded latches which latch into the door frames of all four sets of doors. The facility will install two lock sets for the double leaf corridor doors which do not have handles. The facility will install spring loaded hinges to the 2 sets of doors which do not have spring loaded hinges.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>All residents who eat in the 600 dining room could have the potential to be affected by this action. The facility will install spring loaded latches which latch into the door frames of all four</p>	08/09/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2013
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		
(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	
	3.1-19(b)		sets of doors. The facility will install two lock sets for the double leaf corridor doors which do not have handles. The facility will install spring loaded hinges to the 2 sets of doors which do not have spring loaded hinges. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DPO or designee will monitor/audit new door new spring loaded latches, closures, and lock set to ensure proper mechanical working of the doors weekly times 4 weeks, then monthly times 5 months. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee and Safety Committee monthly for a minimum of 6 months then randomly thereafter for further recommendation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2013	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012			
(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			
K020051 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, 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 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, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 169 smoke detectors were installed in a location which would allow the smoke detector to function to its fullest capability. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 6 residents on 600 hall east as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the tour from 12:05 p.m. to 3:00 p.m. with the Maintenance Supervisor, the smoke detector in the Clean Utility room</p>	K020051	<p>K 051 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The smoke detector in the 600 Clean Utility room was one foot from a ceiling supply vent located where air flow may have prevented the operation of the detector. The facility moved the smoke detector on July 23, 2013 to a location, at least three feet, which would allow the smoke detector to function to its fullest capability. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: In the event of a fire, all residents</p>	08/09/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2013
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		
(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>on 600 hall was one foot from a ceiling supply vent. Based on interview on 07/10/13 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned smoke detector was installed within one foot of an air supply duct in the ceiling which would interfere with the smoke detector's ability to detect smoke to its fullest capability.</p> <p>3.1-19(b)</p>		<p>within the vicinity of the 600 Clean Utility room could have the potential to be affected by this action. The facility moved the smoke detector on July 23, 2013 to a location, at least three feet, which would allow the smoke detector to function to its fullest capability.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DPO or designee will monitor/audit new locations of the smoke detectors to ensure proper mechanical working weekly times 4 weeks, then monthly times 5 months. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee and Safety Committee monthly for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2013	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012			
(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			
K020062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure 2 of 2 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Systems report on 07/10/13 at 3:31 p.m. with the Maintenance Supervisor, the facility lacked documentation of annual inspections for one private fire hydrant outside 600 hall. Based on interview concurrent with record review with the Maintenance Supervisor, it was confirmed documentation of an annual fire hydrant inspection was not available for review.</p>	K020062	<p>K 062Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The facility's two private fire hydrants were not inspected and tested periodically. On July 24, 2013, the facility had the two fire hydrants inspected and put an annual inspection schedule of the facility's fire/sprinkler company.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: In the event of a fire, all residents could have the potential to be affected by this action. On July 24, 2013, the facility had the two fire hydrants inspected and put an annual inspection schedule of the facility's fire/sprinkler company.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The facility had the two fire hydrants inspected on July 24, 2013 and put an annual inspection schedule of the facility's fire/sprinkler company. How the corrective measures will be</p>	08/09/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2013
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		
(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	
	3.1-19(b)		monitored to ensure the alleged deficient practice does not recur: The results of the monitor/ audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee and Safety Committee after the first inspection and then randomly thereafter for further recommendation.		