

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/04/2022
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) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00380533 completed on 6/6/22.</p> <p>This visit was in conjunction with the PSR to the Annual Recertification and State Licensure Survey.</p> <p>Complaint IN00380533 - Corrected</p> <p>Survey dates: August 4, 2022</p> <p>Facility number: 011045</p> <p>Residential Census: 32</p> <p>Bethany Pointe Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00380533.</p> <p>Quality review completed on August 8, 2022.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE