STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155698	A. BUILDING 00 B. WING	06/06/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey and Investigation of Residential Complaint IN00409999. Complaint IN00409999 - No deficiencies related to the allegations are cited. Survey dates: May 30 & 31, June 1, 2, 5 & 6, 2023 Facility number: 011045 Provider number: 155698 AIM number: 200380790 Census Bed Type: SNF/NF: 23 SNF: 29 Residential: 49 Total: 101 Census Payor Type: Medicare: 16 Medicaid: 22 Other: 14 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 9, 2023.	F 0000		
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Alicia Lambert | Executive Director | 06/25/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State			

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	agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision			

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	was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to resolve resident grievances regarding the provision of showers for 1 of 1 residents reviewed for resolution of grievances (Resident 5). Findings include: During an interview on 5/30/23 at 10:59 a.m., Resident 5 indicated she only had three showers this month. The staff always just cleaned her up when she was seated in the bathroom (considered a partial bed bath). She wanted her hair washed as well. Her daughter kept a record of her showers. During a interview on 5/31/23 at 9:54 a.m., Resident 5's daughter indicated the resident got a shower yesterday, which resulted in four showers for the month. She had spoken to the DON. They switched her schedule from third to first shift, in order for her to have a shower before breakfast. Her mother had refused a shower on two occasions, because of the timing. They would get her up, cleaned up and dressed, then wanted to offer a shower later. She was too fatigued to do the dressing, undressing, and redressing process	F 0585	The submission of this plan of correction does not indicate and admission by Bethany Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Bethany Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1. Resident 5 was affected by	06/30/2023

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	twice. She had approached the DON several times, who said she would look into it or take care of it. The problem had yet to be resolved. Resident 5's clinical record was reviewed on 5/31/23 at 2:54 p.m. Current diagnosis included Parkinson's disease, major depressive disorder and muscle weakness. A 4/28/23, annual, Minimum Data Set assessment (MDS) indicated the resident was cognitively intact, did not reject care, and required total assistance from staff for bathing. Review of the electronic medical record bath and shower records for 3/1/23 to 5/31/23, and "shower sheets" documents, provided by the Administrator on 6/5/23 at 2:22 p.m., indicated the resident had received 15 showers during the three month period. During an interview on 6/5/23 at 1:26 p.m., with both the Administrator and DON, the DON indicated she had been the individual involved with Resident 5 and their family's concerns with shower frequency. Review of a "Resident Concern Log," provided by the Administrator on 6/5/23 at 2:22 p.m., indicated the resident had expressed concerns on 2/3/23 regarding shower frequency during the Resident Council meeting. The resident's shower schedule was changed on 2/6/23 and the issue was resolved. No follow-up regarding the satisfaction or success of the solution was documented on the form. Review of the "Resident Concern Log" for March, April, and May 2023, indicated no entries of Resident 5's concerns regarding the frequency of		alleged insufficient practice. Resident 5 grievance reviewed and preferences related to bathing reviewed and updated per resident preference. No adverse effects noted by alleged insufficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. All residents with grievances reviewed to ensure adequate resolution at this time. All staff have been educated on the resident concern process policy. 3. As a measure of ongoing compliance, the DSS or designee to audit all grievances 5 times per week for 4 weeks, 3 times a week for 2 months, then 2 times per week for 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	showers. During an interview on 6/6/23 at 10:35 a.m., the DON indicated she had not been aware Resident 5 was still unsatisfied with the frequency of her showers. A formal plan or care plan had not been developed to ensure the satisfaction with shower frequencies. She had not set a goal of two showers a week for the resident. Her goal had been to improve from the two showers a month the family stated the resident had received in February. No one had specifically audited the resident's shower records to see if the facility had reached a successful resolution. A previous nurse, who was being trained to be a DON, had audited showers in general. She had no documentation of follow-up with the family or resident. She had no documentation of audits for resolution. A current, 12/31/22, facility policy titled "Resident Concern Process", provided by the Administrator on 6/6/23 at 10:56 a.m., indicated the following: "...Take steps to correct the problem. Make the problem their own by following up to make sure it is resolved and stays resolved...." 3.1-7(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.			

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	§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to obtain and administer ordered medications, available from the facility EDK (emergency drug kit), for 1 of 5 residents reviewed for unnecessary medications. (Resident 19) Findings include: Review of Resident 19's clinical record was completed on 5/31/23 at 2:38 p.m. Diagnoses included hypertensive heart disease with heart failure, atrial fibrillation, chronic obstructive pulmonary disease, hypothyroidism, and restless leg syndrome.	F 0755	The submission of this plan of correction does not indicate and admission by Bethany Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Bethany Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby	06/30/2023

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	Review of physician's orders and the resident's electronic administration record (eMAR) for February 2023 indicated a medication was not available for administration as follows: a. The evening doses on 2/13/23 and 2/14/23 of amoxicillin-pot clavulanate (an antibiotic) 875-125 mg (milligram), twice daily for acute bronchitis. Review of the resident's eMAR for March 2023 indicated a medication was not available for administration as follows: a. The 3/27/23 morning dose of Eliquis (to thin the blood) 5 mg, twice daily. b. The 3/27/23 dose of levothyroxine (to treat hyperthyroidism) 50 mcg (microgram), one tablet daily. Review of physician's orders and the resident's eMAR for April 2023 indicated a medication was not available for administration as follows: a. The 4/12/23 morning dose of Eliquis 5 mg. b. The 3/27/23 dose of potassium chloride (to treat hypokalemia) extended release 10 meq (milliequivilants), two tables at bedtime. c. The 4/27/23 mid-morning dose of torsemide (a diuretic) 20 mg, two tables twice daily. Review of physician's orders and the resident's eMAR for May 2023 indicated a medication was not available for administration as follows: a. The 5/18/23 dose of gabapentin (to treat nerve pain) 100 mg, three tablets at bedtime.		maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1. Resident 19 was affected by alleged insufficient practice. Resident's medications have been reviewed and all orders are up to date with all medications available for administration. No adverse effects noted. 2. All residents have the potential to be affected by the alleged deficient practice. Emar compliance reviewed for all residents to ensure all medications were available at this time. Licensed staff have been educated on the medication administration policy related to pulling from the EDK. 3. As a measure of ongoing compliance, the DHS or designee to audit all resident medication administration record to ensure proper medication administration, including but not limited to usage of the EDK, 5 times per week for 4 weeks, 3 times a week for 2 months, then 2 times per week for 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or	

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	A review of the facility EDK inventory list, provided by the Administrator on 6/5/23 at 11:48 a.m., indicated it included the following medications: amoxicillin clavulanate 875-125 mg tablets, Eliquis 2.5 mg tablets, gabapentin 300 mg, levothyroxine 25 mcg tablets, potassium chloride extended release 10 meq capsules, and torsemide 20 mg tablets. During an interview on 6/5/23 at 10:13 a.m., the DON indicated if a medication was unavailable in the medication cart, the EDK should be accessed to obtain medication if available. During an interview on 6/6/23 at 10:38 a.m., LPN 3 indicated if a medication was not available in the medication cart, the overflow medication supply should be checked for unavailable medications. If the medication was not in overflow, she would obtain it if available, from the EDK or, if not, call the pharmacy to see about a delivery and to assure the medication had been ordered. During an interview on 6/6/23 at 11:08 a.m., LPN 5 indicated when a medication was not present in the medication cart, it should be pulled from the EDK. If the EDK did not have the medication available, the pharmacy should deliver the medication immediately or with the next delivery as appropriate. A current facility policy, revised 11/18, titled "Medication Administration-General Guidelines," provided by the Administrator on 6/5/23 at 11:48 a.m., indicated the following: "Policy: ...The facility has sufficient personnel and a medication distribution system to ensure safe administration of medications without unnecessary interruptions....A. Preparation...11. If a medication with a current, active order cannot be located in		designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	the medication cart/drawer, other areas of the medication cart, medication room and facility (e.g., other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication may be removed from the emergency drug supply." 3.1-25(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey and Investigation of Residential Complaint IN00409999. This visit included a Recertification and State Licensure Survey. Complaint IN00409999 - No deficiencies related to the allegations are cited. Survey dates: May 30 & 31, June 1, 2, 5 & 6, 2023 Facility number: 011045 Residential Census: 49 Bethany Pointe Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Residential Complaint IN00409999. Quality review completed June 9, 2023.	R 0000		