STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155698	A. BUILDING -- B. WING	06/14/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/14/23 Facility Number: 011045 Provider Number: 155698 AIM Number: 200380790 At this Emergency Preparedness survey, Bethany Pointe Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 74 and had a census of 45 at the time of this survey. Quality Review conducted on 06/16/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/14/2023 Facility Number: 011045 Provider Number: 155698 AIM Number: 200380790 At this Life Safety Code survey, Bethany Pointe Health Campus was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia Lambert	Executive Director	06/30/2023

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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 74 and had a census of 45 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. There was a 30 minute fire separation instead of the required 2 hour fire separation between the Nursing facility and adjoining Assisted Living facility, therefore the Assisted Living facility was also surveyed. Quality Review conducted on 06/16/23			
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that			

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	do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strip in resident sleeping room 620 meets UL 1363. This deficient practice could affect up to 2 residents. Findings include: Based on observation with the Director of Plant Operations (DPO) on 06/14/23 at 2:05 p.m., in the resident sleeping room 620 there was a power strip in use that did not meet UL-1363. Based on interview at the time of observation, the DPO agreed a power strip was in use in the resident sleeping room 620 and did not meet UL-1363. The power strip was removed at the time of discovery. This finding was reviewed with the Executive Director and the DPO during the exit conference. 3.1-19(b)	K 0920	Education regarding usage of power cords and extensions completed for all maintenance employees. Power strip immediately removed per code. Up to 2 residents have the potential to be affected by the alleged deficient practice. As a measure of ongoing compliance, the DPO or designee to audit 5 resident rooms 3x weekly for 4 weeks, 2x weekly for 3 months, and weekly for 2 months or until 100% compliance is maintained. 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.	06/14/2023
K 0923 SS=E	NFPA 101 Gas Equipment - Cylinder and Container			

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Bldg. 01	Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.			

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	11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 3 of 10 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 10 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Director of Plant Operations (DPO) on 06/14/23 at 1:45 p.m., three 'E' type oxygen cylinders were standing upright on the floor of the oxygen storage/trans-filling room and were not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the DPO acknowledged three 'E' type oxygen cylinders in the oxygen storage/trans-filling room were not properly chained or supported in a proper cylinder stand or cart. The 3 E type oxygen cylinders were secured by the DPO at the time of discovery. The finding was reviewed with the Executive Director and the DPO during the exit conference. 3.1-19(b)	K 0923	§ Education regarding proper storage of nonflammable gases such as oxygen were properly secured from falling completed for all employees. Cylinders were immediately secured per code. Up to 10 residents have the potential to be affected by the alleged deficient practice. As a measure of ongoing compliance, the DPO or designee to audit for proper storage of cylinders 3x weekly for 4 weeks, 2x weekly for 3 months, and weekly for 2 months or until 100% compliance is maintained. 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.	06/15/2023

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	155698	A. BUILDING 02 B. WING	06/14/2023

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K 0222 SS=E Bldg. 02	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS			

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	Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure 1 of 6 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall	K 0222	Education regarding egress door life safety code completed for all maintenance employees. Egress door repaired on June 26, 2023 and are operational per code. Up to 10 residents have the potential to be affected by the alleged deficient practice. As a measure of ongoing compliance, the DPO or designee to audit all egress doors 3x weekly for 4 weeks, 2x weekly for 3 months, and weekly for 2 months or until 100% compliance is maintained. As a quality measure, the Executive	06/26/2023

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	activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect up to 10 residents in the Assisted Living living room. Findings include: Based on observation during a tour of the facility with the Director of Plant Operations (DPO) on 06/14/23 at 1:35 p.m., the Assisted Living living room exit door was equipped with a 15 second delayed egress. When the exit door was tested the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the DPO made adjustments and tried 3 times to activate the delayed egress and stated the delayed egress is not working and will need to be repaired. This finding was reviewed with the Executive Director and DPO during the exit conference. 3.1-19(b)		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.	
K 0355 SS=E Bldg. 02	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 1 portable fire extinguishers by the Assisted Living Nursing Office each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire	K 0355	~~§~~ Education regarding adequate inspection for portable fire extinguishers completed for all maintenance employees. Portable fire extinguisher manual inspection	06/14/2023

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	extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect staff and residents in the area of Assisted Living Nursing Office. Findings include: Based on observation during a tour of the facility with the Director of Plant Operations (DPO) on		tag immediately inspected and corrected with sufficient date. Up to 29 residents have the potential to be affected by the alleged deficient practice. As a measure of ongoing compliance, the DPO or designee to audit all portable fire extinguishers for proper inspection dates 1x weekly for 4 weeks, 1x every other week for 3 months, and monthly for 2 months or until 100% compliance is maintained. 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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	06/14/23 at 1:30 p.m., the monthly inspection tag on the fire extinguisher located by the Assisted Living Nursing Office lacked documentation of a monthly inspections for February 2023 to May 2023. Based on interview at the time of observation, the DPO confirmed the fire extinguisher located by the Assisted Living Nursing Office was missing the February 2023 - May 2023 monthly visual inspection. This finding was reviewed with the Executive Director and DPO at the exit conference. 3.1-19(b)			