STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155698	A. BUILDING 01 B. WING	08/08/2023

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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 06/14/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 08/08/23 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 the Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.90(a). The facility has 74 certified beds. At the time of survey the census was 49. Quality Review completed on 08/28/23	K 0000		
K 0222 SS=E Bldg. 01	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			

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

Alicia Lambert | Executive Director | 09/01/2023

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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	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 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.			

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	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 the means of egress through 1 of 10 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.(3)(4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 20 residents from Legacy Lane (memory care unit). Findings include: Based on observations during tour of the facility with the Director of Plant Operations (DPO) on 08/08/23 at 1:35 p.m., the double door exit located in Legacy Lane Way were provided with delayed egress locks but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. This double door had signage on one door but the other door had over half of the sign missing. Based on interview at the time of observation, the DPO acknowledged the door was equipped with a delayed egress and lacked the proper signage. This deficiency was	K 0222	Education regarding proper signage indicating the doors can be opened in 15 seconds by pushing on the door for all maintenance employees. The alleged deficient practice could affect 13 residents. Proper signage placed on August 16, 2023 for identified door. As a measure of ongoing compliance, the DPO or designee to audit for proper signage on 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 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.	09/01/2023

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	observed during the PSR survey. This finding was reviewed with the Executive Director and DPO at the exit conference. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)			

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	g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 oxygen room, which is a hazardous area, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could 10 residents in the corridor by the oxygen storage area. Findings include: Based on observations during a tour of the facility with the Director of Plant Operations (DPO) on 08/08/23 at 01:30 p.m., the oxygen storage room was equipped with a self-closing device but did not latch into the frame when tested. Based on interview at the time of observation, the DPO agreed that when tested, the oxygen storage room, which is a hazardous area, with a self-closing device on the door that did not latch into the frame. This deficiency was observed during the PSR survey. This finding was reviewed with the Executive Director and DPO at the exit conference. 3.1-19(b)	K 0321	· Education regarding proper latching of hazardous area doors completed for all maintenance employees. The alleged deficient practice could affect 10 residents. Oxygen storage room door was repaired on August 8, 2023 and is operational per code. As a measure of ongoing compliance, the DPO or designee to audit all hazardous area doors for proper latch 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.	09/01/2023