STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155546	A. BUILDING -- B. WING	05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHEL POINTE HEALTH AND REHAB	3400 W COMMUNITY DR MUNCIE, IN 47304

(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: 05/23/23 Facility Number: 000565 Provider Number: 155546 AIM Number: 100267630 At this Emergency Preparedness survey, Bethel Pointe Health and Rehabilitation 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 114 and had a census of 103 at the time of this survey. Quality Review completed on 05/30/23	E 0000	The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facility's desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.	
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: 05/23/2023 Facility Number: 000565 Provider Number: 155546 AIM Number: 100267630 At this Life Safety Code survey, Bethel Pointe Health and Rehabilitation was found not in compliance with Requirements for Participation in	K 0000	The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facility's desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Derek Gibson		06/08/2023

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 resident sleeping rooms. The facility has a capacity of 114 and had a census of 103 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 05/30/23			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 3 of 3 smoke barrier doors. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff and residents in three smoke compartment areas. Findings include:	K 0100	1. No residents were affected. 2. All residents have the potential to be affected. 3. The Director of Plant Operations immediately fixed the latching hardware on Doors #2, #5, and #12 (See Attachments A, B, and C). The Director of Plant	06/08/2023

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	Based on observation with the Director of Plant Operations (DPO) on 05/23/23 between 1:00 p.m. and 1:40 p.m., the sets of #2, #5, and #12 smoke barrier doors were provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the DPO agreed the smoke doors were equipped with latching devices, but the doors did not properly latch when tested. The finding was reviewed with the Administrator and DPO during the exit conference. 3.1-19(b)		Operations was educated on the NFPA/LSC requirement for latching hardware on Fire/Smoke Barrier Doors. The DPO or his designee will make weekly rounds to ensure fire doors latch properly until 100% compliance is achieved for 6 weeks, and then monthly thereafter ongoing. 4. The findings of these audits will be discussed in the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure penetrations through smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC	K 0372	1. No residents were affected. 2. All residents have the potential to be affected. 3. The Director of Plant Operations immediately installed fire caulking	06/08/2023

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	Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 30 residents in two smoke compartments. Findings include: Based on observation with the Director of Plant Operations on 05/23/23 at 2:10 p.m., above the drop ceiling of the smoke wall above smoke door #2 there was a half inch gap around a penetration for communication wires. Based on interview at the time of observation, the DPO agreed there was an unsealed penetration in the smoke barrier above smoke door #2. The finding was reviewed with the Administrator and DPO during the exit conference. 3.1-19(b)		around the penetration to ensure penetration was completely sealed above Door #2 (See Attachment D). The Director of Plant Operations was educated on the requirement for protection of smoke barrier walls with penetrations in accordance with NFPA/LSC. The DPO or his designee will make weekly rounds to ensure all penetrations in smoke barrier walls are completely sealed until 100% compliance is achieved for 6 weeks, and then monthly thereafter ongoing. 4. The findings of these audits will be discussed in the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	
K 0761 SS=C Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure the annual inspection and testing of fire door assemblies was completed in accordance with NFPA 80,	K 0761	1. No residents were affected. 2. All residents have the potential to be affected.	06/08/2023

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	Standard for Fire Doors and Other Opening Protectives. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include:		3. The Director of Plant Operations immediately put each set of fire doors on separate annual inspection sheets (See Attachment E). The DPO was educated on the requirement for annual fire door inspections to be put on separate inspections sheets in accordance with NFPA/LSC. The DPO will ensure each set of fire doors have their own inspection sheet for each year moving forward. 4. The findings of these audits will be discussed in the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	Based on record review with the Director of Plant Operations (DPO) on 05/23/23 documentation of an annual inspection for the fire door assemblies was available for review but was listed as an annual inspection on all 6 Fire/Smoke Doors completed 03/17/23. There was no identification of the location of each door and all doors were on the same inspection document. Based on interview at the time of records review and observation, the DPO stated he was unaware that the annual fire door inspection needed to show the location of each door and a separate inspection sheet is needed for each one. This finding was reviewed with the Administrator and DPO at the exit conference. 3.1-19(b)			