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	07/08/2024

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: 07/08/24 Facility Number: 000565 Provider Number: 155546 AIM Number: 100267630 At this Emergency Preparedness survey, Bethel Pointe Rehabilitation Center-Muncie was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 114 certified beds. At the time of the survey, the census was 103. Quality Review completed on 07/10/24	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 facilities 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: 07/08/24 Facility Number: 000565 Provider Number: 155546 AIM Number: 100267630 At this Life Safety Code survey, Bethel Pointe	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 facilities 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
Selina Holloway	HFA	07/23/2024

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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	Health and Rehabilitation Center of Muncie was found not in compliance with Requirements for Participation in 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 (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard-wired detectors in all resident sleeping rooms. The facility has a capacity of 114 and had a census of 103 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one garage used for storage which was not sprinklered. Quality Review completed on 07/10/24			
K 0222 SS=F 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 be made for the rapid removal of occupants by: remote control of locks; keying of all			

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	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. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS			

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	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 9 of the facility's exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect everyone in the facility. Findings include: Based on observations and interviews during a tour of the facility with the Director of Plant Operations (DPO), Administrator and Regional Maintenance Support representative on 07/08/24 between 12:20 p.m. and 2:45 p.m., the following exit doors, marked as facility exits, were magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exits: A) Front Door main entrance (code was hidden under the arm of the door hinge. B) Door #10 at the time of the survey, the DPO and the Regional Support Rep. did not know the code to exit this door. C) Door # 13 D) Door # 14	K 0222	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were affected. All egress doors were checked during the survey. All were labeled near the door with the exit code immediately following the conclusion of the survey. 2. All residents have the potential to be affected and all egress doors were labeled near the door with the exit code. 3. Maintenance staff will be educated on K-0222. The DPO or his designee will check all egress doors weekly for 6 weeks and until 100% compliance is achieved, then monthly for 6 months and until 100% compliance is maintained to ensure the exit codes are posted near the egress doors. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	07/26/2024

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	E) Door # 15 F) Door # 4 G) Door # 6 H) Door # 7 I) Door # 12 This finding was acknowledged by the DPO at the time of discovery and again at the exit conference with the (DPO), Administrator and Regional Maintenance Support representative all present. 3.1-19(b)			
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors,	K 0345	The facility will ensure compliance through the following corrective measures: 1. No residents were affected. Visual inspection of the fire alarm system was completed immediately following the survey exit. 2. All residents have the potential to be affected. Visual inspection of the fire alarm system was completed immediately following the survey exit. 3. The maintenance staff were	07/26/2024

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	etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on records review and interview with the Director of Plant Operations (DPO), the Administrator and Regional Maintenance Support representative on 07/08/24 between 10:10 a.m. and 11:45 p.m., no documentation could be provided regarding a visual semi-annual fire alarm system inspection. During the survey, the DPO reached out to the facility's provider for the missing documentation but was unable to locate any further documentation. This finding was acknowledged by the DPO at the time of discovery and again at the exit conference with the (DPO), Administrator and Regional Maintenance Support representative all present. 3.1-19(b)		educated on K-0345. The HFA or her designee will audit maintenance documentation monthly for 6 months and until 100% compliance is achieved, then every six months thereafter to ensure visual fire inspections are completed semi-annually and 100% compliance. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching			

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	hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff and 4 residents. Findings include: Based on observations and interviews during a tour of the facility with the Director of Plant	K 0363	The facility will ensure this requirement is met through the following corrective measures: 1. No residents or staff were harmed. Corridor doors into room 221 and the 100 Hall shower room were immediately repaired and able to close and latch. 2. All residents have the potential to be affected. 100% of all facility corridor doors were checked to	07/26/2024

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	Operations (DPO), Administrator and Regional Maintenance Support representative on 07/08/24 between 12:20 p.m. and 2:45 p.m., the corridor door to (1) Resident room #221 and (2) the Shower Room on the 100 hall (equipped with a self-closing device) failed to close and latch positively into their respective door frames. Based on interview at the time of the observations, the DPO agreed the aforementioned doors did not close and latch into the door frames and would not resist the passage of smoke. This finding was acknowledged by the DPO at the time of discovery and again at the exit conference with the (DPO), Administrator and Regional Maintenance Support representative all present. 3.1-19(b)		ensure closure and latch could be achieved. Repairs were made when indicated. 3. The maintenance staff were educated on F-0363. The DPO or his designee will check all corridor doors every 2 weeks to ensure closure and latch mechanisms are in working order. The audits will be completed for 6 weeks, then monthly thereafter. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	
K 0920 SS=E 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 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			

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	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 2 of 2 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 4 staff in the employee break room and activities area. Findings include: Based on observations and interviews during a tour of the facility with the Director of Plant Operations (DPO), Administrator and Regional Maintenance Support representative on 07/08/24 between 12:20 p.m. and 2:45 p.m., in the (1) Employee Break Room had an extension cord which was powering a power strip was being used to power a vending machine. And in (2) the Activities Office, a power strip was being used to power a microwave oven (high power draw equipment). This finding was acknowledged by the DPO at the time of discovery and again at the exit conference with the (DPO), Administrator and Regional Maintenance Support representative all present. 3.1-19(b)	K 0920	The facility will ensure this requirement is met through the following corrective measures: 1. No residents or staff were harmed. Extension cords were removed and both the vending machines and the microwave were plugged directly into the wall outlets. 2. All residents and staff have the potential to be harmed. Rounds were completed to ensure no other high-draw equipment was plugged into extension cords. 3. The maintenance staff were educated on K-0920. The DPO or his designee will facility rounds every other week to ensure power strips are not in use for high draw equipment. These audits will continue for 6 weeks then monthly thereafter to ensure continued compliance. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	07/26/2024