

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/28/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155546		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2023	
NAME OF PROVIDER OR SUPPLIER BETHEL POINTE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 3400 W COMMUNITY DR MUNCIE, IN 47304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00404415, IN00404021, IN00400209, IN00401833, IN00403444, IN00403829 and IN00403546 .</p> <p>Complaint IN00404415 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00404021 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00400209 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00401833 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00403444 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00403829 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00403546 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: March 21, 22 and 23, 2023</p> <p>Facility number: 000565 Provider number: 155546 AIM number: 100267630</p> <p>Census Bed Type: SNF/NF: 92 SNF: 10 Total: 102</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 000	<p>Continued From page 1</p> <p>Census Payor Type: Medicare: 27 Medicaid: 56 Other: 19 Total: 102</p> <p>Bethel Pointe Health And Rehab was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00404415, IN00404021, IN00400209, IN00401833, IN00403444, IN00403829 and IN00403546.</p> <p>Quality review completed March 27, 2023.</p>	F 000			