Selina Holloway

continued program participation.

PRINTED: 04/23/2025 FORM APPROVED OMB NO. 0938-039

04/21/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155546		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY  COMPLETED  04/09/2025		
NAME OF PROVIDER OR SUPPLIER  BETHEL POINTE HEALTH AND REHAB			3400 V	ADDRESS, CITY, STATE, ZIP COD V COMMUNITY DR EIE, IN 47304	
(X4) ID PREFIX TAG E 0000	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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 04/09/25  Facility Number: 000565 Provider Number: 155546 AIM Number: 100267630  At this Emergency Preparedness survey, Bethel Pointe Health and Rehab 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 107.  Quality Review completed on 04/10/25		E 0000	The completion of this plan of correction does not constitute admission that the alleged deficiency exists. The plan of correction is provided as evide of the facilities desire to compl with the regulations and contint to provide quality care in a saf environment.  The facility is requesting a desireview for compliance.	ence ly nue ie
K 0000 Bldg. 01	A Life Safety Code Licensure Survey of Department of Hea 483.90(a). Survey Date: 04/0 Facility Number: 0 Provider Number: AIM Number: 100 At this Life Safety Health and Rehab	e Recertification and State was conducted by the Indiana alth in accordance with 42 CFR  9/25  000565  155546 0267630  Code survey, Bethel Pointe was found not in compliance	K 0000	The completion of this plan of correction does not constitute admission that the alleged deficiency exists. The plan of correction is provided as evide of the facilities desire to compl with the regulations and contint to provide quality care in a saf environment.  The facility is requesting a desireview for compliance.	ence ly nue ie
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE

Any defiency statement 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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to

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**HFA** 

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155546		(X2) MULTIPLE CONSTRUCTION       (X3) DATE :         A. BUILDING       01       COMPL         B. WING       04/09/							
	NAME OF PROVIDER OR SUPPLIER BETHEL POINTE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COD  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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR TAG DEFICIENCY)		LD BE	(X5) COMPLETION DATE			
	with Requirements Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (I Building 01, consist building constructed determined to be of fully sprinklered. T system with smoke spaces open to the of detectors in all resic 01 was surveyed un Health Care Occupa Building 02, constructed facility and consists rooms 227 through to the renovated Th determined to be of fully sprinklered. T system with smoke spaces open to the of detectors in all resic 02 was surveyed un Care Occupancies a The facility has a ca census of 107 at the All areas where resi were sprinklered an services were sprinl used for storage wh	for Participation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, SC).  Its of the existing one story d in 1994 which was Type V (000) construction and the facility has a fire alarm detection in the corridors, corridors, and hard-wired dent sleeping rooms. Building der Chapter 19, Existing ancies and 410 IAC 16.2.  Letted in 2019, is a one story of new resident sleeping 252 and a connecting hallway erapy Room and was Type V (111) construction and the facility has a fire alarm detection in the corridors, corridors, and hard-wired dent sleeping rooms. Building der Chapter 18, New Health and 410 IAC 16.2.							
K 0200 SS=D	NFPA 101 Means of Egress	Requirements - Other							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155546	B. WING			04/09/2025	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
DETUE		AND DELLAD			COMMUNITY DR		
BETHEL	POINTE HEALTH A	AND REHAB		MUNCI	E, IN 47304		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
Bldg. 01							
	Based on observation	on and interview, the facility	K 02	200	The facility will ensure this		04/21/2025
	failed to ensure 1 of	2 exit doors from the Therapy			requirement is met through the	۔	
	Room was provided	with doors which required			following corrective measures:		
	only one operation t	to open. LSC 19.2.2.1 states			1. No residents were affected.	The	
	doors complying wi	th LSC 7.2.1 shall be permitted.			sliding bolt was not in use duri	ng	
	LSC 7.2.1.5.10.2 re	quires the releasing mechanism			the survey. The sliding bolt wa	ıs	
	shall open the door	leaf with not more than one			removed from the exit door fro	m	
	releasing operation.	This deficient practice could			the therapy room immediately		
	affect over two resid	dents and staff if needing to			following the survey.		
	exit the Therapy Ro	om.			2. Over two residents and staf	f	
					have the potential to be affected	∍d.	
	Findings include:				Sliding bolt was immediately		
					removed from the exit door from		
	Based on observations with the Administrator				the therapy room.		
	and the Director of Plant Operations (DPO) at 1:23				3. Maintenance staff will be		
	p.m. on 04/09/25, the exit door from the Therapy				educated on K-0200. The HFA	or	
	Room to the new connecting hallway was				her designee will check the ex	it	
	equipped with a sliding bolt on the room side of				door from the therapy room to		
		to the locking door handle.			ensure that it requires only one	Э	
	Based on interview				operation to open once a weel	∢ for	
	observations, the DPO agreed the Therapy Room				6 weeks and until 100%		
	exit door had an independent sliding bolt in				compliance is achieved, then		
		ng door handle and required			monthly for 6 months and until		
		ation to release the door to			100% compliance is maintaine	d to	
		ing slide bolt was used to lock			ensure the door requires one		
	the door.				operation to open.		
					4. The findings of these audits		
	These findings were				be presented during the facility		
		he DPO during the exit			monthly QAPI meetings and the	ie	
	conference.				plan of action adjusted		
	2.1.10(1)				accordingly.		
	3.1-19(b)						
K 0321	NFPA 101						
SS=E	Hazardous Areas	Enclosuro					
Bldg. 01	i iazaiuuus Aleas	- LINUSUIC					
Diag. 01	Based on observation	on and interview, the facility	K 0	221	The facility will ensure this		04/21/2025
		Fover 13 hazardous areas such	N U.	041	requirement is met through the	_	0 <del>4</del> /21/2023
					following corrective measures:		
	as fuel-fired heater rooms were separated from				iollowing corrective measures:		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED			
		155546	B. W	B. WING		04/09/2025		
				CERET	ADDRESS OF A STATE OF COD			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
			3400 W COMMUNITY DR					
BETHEL	POINTE HEALTH /	AND REHAB		MUNCIE, IN 47304				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	other spaces by smo	oke resistant partitions and			1. No residents were affected.			
	doors. Doors shall	be self closing or automatic			Smoke resistant partitions wer	e		
	closing in accordan	ce with 7.2.1.8. This deficient			immediately cut to an appropri	ate		
	practice could affec	et over 20 residents, staff and			size in the attic access areas a	and		
	visitors.				the previous smoke resistant			
					partitions were removed to en	sure		
	Findings include:				the hazardous areas were			
					separated from other spaces			
	Based on observation	ons with the Administrator			appropriately.			
	and the Director of	Plant Operations (DPO) at 1:33			2. Over 20 residents, staff and			
	p.m. on 04/09/25, tl	ne three foot by one foot attic			visitors have the potential to be	е		
	access panel in the	ceiling of the Mechanical			affected. Smoke resistant			
	Room near the end	of the service hall did not			partitions were immediately cut to			
	completely cover th	ne opening for this attic access			an appropriate size in the attic			
	and exposed the att	ic above. The Mechanical			access areas and the previous			
	Room contained tw	o natural gas fired furnaces.			smoke resistant partitions were			
	Based on interview	at 1:33 p.m. on 04/09/25, the			removed to ensure the hazardous			
	DPO agreed the acc	cess panel in the ceiling of the			areas were separated from oth	ner		
	Mechanical Room	did not completely cover the			spaces appropriately.			
	opening for the attic	c access and exposed the attic			3. The maintenance staff were			
	above.				educated on K-0321. The DP0	O or		
					his designee will audit all attic			
		ons with the Administrator			access areas weekly for 6 wee	eks		
		8 p.m. on 04/09/25, the two foot			and until 100% compliance is			
	1	ic access panel in the ceiling			achieved, then monthly for 6			
		Office did not completely			months to ensure the smoke			
		or this attic access and			resistant partitions are separat	ting		
	_	ove. The Maintenance Office			the hazardous areas from other	er		
		ral gas fired furnaces. Based			spaces appropriately.			
		3 p.m. on 04/09/25, the DPO			4. The findings of these audits	s will		
		anel in the ceiling of the			be presented during the facility			
		did not completely cover the			monthly QAPI meetings and th	ne		
	opening for the attic access and exposed the attic				plan of action adjusted			
	above.				accordingly.			
	These findings were							
		he DPO during the exit						
	conference.							
	3.1-19(b)							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		COMPLETED	
		155546	B. W	B. WING		04/09/2025	
NAME OF PROVIDER OR SUPPLIER BETHEL POINTE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 3400 W COMMUNITY DR MUNCIE, IN 47304				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG			TAG		DEFICIENCY)	IIE	DATE
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extir  Based on observation failed to ensure 1 of were inspected at les inspections were do and initials of the perinspection in accordance with NF standard for Portable Edition, Section 7.2 shall be inspected en electronic monitor minimum of 30-day manual inspections manual inspections manual inspection of the person performed. Where merconducted, records to be kept on a tag or lextinguisher, on an maintained on file, or Records shall be kept the last 12 monthly performed. This decover 10 residents, stof the Beauty Shop.  Findings include:  Based on observation and the Director of p.m. on 04/09/25, the portable fire extinguisher and documentation on the standard shall be setting the standard shall shall be setting the standard shall s	on and interview, the facility (26 portable fire extinguishers ast monthly and the cumented including the date erson performing the lance with NFPA 10. LSC ole fire extinguishers shall be inspected and maintained in PA 10. NFPA 10, the le Fire Extinguishers, 2010 (1.2 states fire extinguishers ither manually or by means of oring device/system at a intervals. Where monthly are conducted, the date the was performed and the initials ming the inspections are for manual inspections are for manual inspections are for manual inspections shall abel attached to the fire inspection checklist or by an electronic method, but to demonstrate that at least inspections have been ficient practice could affect aff and visitors in the vicinity ons with the Administrator Plant Operations (DPO) at 1:21 are wall mounted ABC type hisher installed in the Beauty	K 0		The facility will ensure this requirement is met through the following corrective measures 1. No residents were affected portable fire extinguisher ident as lacking proper documentati for inspection was immediately inspected. After inspection, the DPO immediately documented the fire extinguisher tag the datand initials of the person performing the inspection.  2. Over 10 residents, staff and visitors in the vicinity of the Beschop have the potential to be affected. 100% of all facility firextinguishers were checked to ensure they had been inspection and that the inspection was properly documented.  3. The maintenance staff were educated on K-0355. The DPO his designee will check all fire extinguishers bi-weekly for 6 weeks and until 100% complia is achieved, then monthly for 6 months and until 100% compliance is maintained to ensure fire extinguishers do not lack proper documentation aft inspection.  4. The findings of these audit be presented during the facility monthly QAPI meetings and the plan of action adjusted accordingly.	: The tified ion y e d on ate deauty e d or ance 6 ot er s will y's	04/21/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155546		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  04/09/2025	
	PROVIDER OR SUPPLIER		3400 W	ADDRESS, CITY, STATE, ZIP COD V COMMUNITY DR IE, IN 47304	
(X4) ID PREFIX TAG	REFIX REGULATORY OR LSC IDENTIFYING INFORMATION  December 2024. The portable fire extinguisher inspection contractor had affixed a hanging tag to the fire extinguisher stating the most recent annual maintenance was performed in April 2024.  Based on interview at 1:21 p.m. on 04/09/25, the DPO stated additional monthly fire extinguisher inspection documentation was not available for review and agreed the aforementioned portable fire extinguisher location had missing monthly inspection documentation for December 2024.  These findings were reviewed with the Administrator and the DPO during the exit conference.  3.1-19(b)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0000					
Bldg. 02	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 04/09  Facility Number: 0 Provider Number: 1002  At this Life Safety 0 Health and Rehab w with Requirements Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L	200565 155546 267630 Code survey, Bethel Pointe vas found not in compliance for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the stion Association (NFPA) 101,	K 0000	The completion of this plan of correction does not constitute admission that the alleged deficiency exists. The plan of correction is provided as evid of the facilities desire to comp with the regulations and conti to provide quality care in a sa environment.  The facility is requesting a de review for compliance.	ence oly nue fe

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

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building 02		COMPLETED	
		155546	B. WING		04/09/2025	
			CERTER	A DEDEGG COMMA CTATE THE COD		
NAME OF I	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD  / COMMUNITY DR		
RETHEI	POINTE HEALTH A	AND REHAR		E, IN 47304		
DETTILL	· · · · · · · · · · · · · · · · · · ·	AND INCLIAD	MONCI	L, IIV 47304		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETIC	ON
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		d in 1994 which was				
		Type V (000) construction and				
	fully sprinklered. T	he facility has a fire alarm				
	system with smoke	detection in the corridors,				
	spaces open to the c	corridors, and hard-wired				
	detectors in all resid	lent sleeping rooms. Building				
	01 was surveyed un	der Chapter 19, Existing				
	Health Care Occupa	ancies and 410 IAC 16.2.				
	Building 02, constru	acted in 2019, is a one story				
	facility and consists	of new resident sleeping				
	rooms 227 through	252 and a connecting hallway				
		erapy Room and was				
		Type V (111) construction and				
		The facility has a fire alarm				
		detection in the corridors,				
	1 · ·	corridors, and hard-wired				
		lent sleeping rooms. Building				
		der Chapter 18, New Health				
	Care Occupancies a	-				
	Care Occupancies a	110 11 to 10.2.				
	The facility has a ca	apacity of 114 and had a				
	census of 107 at the					
	Solibus of 107 at the	time of time viole.				
	All areas where resi	idents have customary access				
		d all areas providing facility				
	•	klered except for one garage				
	_	ich was not sprinklered.				
	ased for storage will	ien was not sprinkiered.				
	Quality Review con	npleted on 04/10/25				

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