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	04/09/2025

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: 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 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: 04/09/25 Facility Number: 000565 Provider Number: 155546 AIM Number: 100267630 At this Life Safety Code survey, Bethel Pointe Health and Rehab was found not in compliance	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	04/21/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155546	A. BUILDING 01 B. WING	04/09/2025

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

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	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). Building 01, consists of the existing one story building constructed in 1994 which 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. Building 01 was surveyed under Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. Building 02, constructed in 2019, is a one story facility and consists of new resident sleeping rooms 227 through 252 and a connecting hallway to the renovated Therapy Room and was determined to be of Type V (111) 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. Building 02 was surveyed under Chapter 18, New Health Care Occupancies and 410 IAC 16.2. The facility has a capacity of 114 and had a census of 107 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 04/10/25			
K 0200 SS=D	NFPA 101 Means of Egress Requirements - Other			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155546	A. BUILDING 01 B. WING	04/09/2025

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
Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of 2 exit doors from the Therapy Room was provided with doors which required only one operation to open. LSC 19.2.2.1 states doors complying with LSC 7.2.1 shall be permitted. LSC 7.2.1.5.10.2 requires the releasing mechanism shall open the door leaf with not more than one releasing operation. This deficient practice could affect over two residents and staff if needing to exit the Therapy Room. Findings include: Based on observations with the Administrator and the Director of Plant Operations (DPO) at 1:23 p.m. on 04/09/25, the exit door from the Therapy Room to the new connecting hallway was equipped with a sliding bolt on the room side of the door in addition to the locking door handle. Based on interview at the time of the observations, the DPO agreed the Therapy Room exit door had an independent sliding bolt in addition to the locking door handle and required more than one operation to release the door to open when the locking slide bolt was used to lock the door. These findings were reviewed with the Administrator and the DPO during the exit conference. 3.1-19(b)	K 0200	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were affected. The sliding bolt was not in use during the survey. The sliding bolt was removed from the exit door from the therapy room immediately following the survey. 2. Over two residents and staff have the potential to be affected. Sliding bolt was immediately removed from the exit door from the therapy room. 3. Maintenance staff will be educated on K-0200. The HFA or her designee will check the exit door from the therapy room to ensure that it requires only one operation to open once a week for 6 weeks and until 100% compliance is achieved, then monthly for 6 months and until 100% compliance is maintained to ensure the door requires one operation to open. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	04/21/2025
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 2 of over 13 hazardous areas such as fuel-fired heater rooms were separated from	K 0321	The facility will ensure this requirement is met through the following corrective measures:	04/21/2025

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	155546	A. BUILDING 01 B. WING	04/09/2025

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

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	other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Administrator and the Director of Plant Operations (DPO) at 1:33 p.m. on 04/09/25, the three foot by one foot attic access panel in the ceiling of the Mechanical Room near the end of the service hall did not completely cover the opening for this attic access and exposed the attic above. The Mechanical Room contained two natural gas fired furnaces. Based on interview at 1:33 p.m. on 04/09/25, the DPO agreed the access panel in the ceiling of the Mechanical Room did not completely cover the opening for the attic access and exposed the attic above. Based on observations with the Administrator and the DPO at 1:48 p.m. on 04/09/25, the two foot by eighteen inch attic access panel in the ceiling of the Maintenance Office did not completely cover the opening for this attic access and exposed the attic above. The Maintenance Office contained two natural gas fired furnaces. Based on interview at 1:48 p.m. on 04/09/25, the DPO agreed the access panel in the ceiling of the Mechanical Room did not completely cover the opening for the attic access and exposed the attic above. These findings were reviewed with the Administrator and the DPO during the exit conference. 3.1-19(b)		1. No residents were affected. Smoke resistant partitions were immediately cut to an appropriate size in the attic access areas and the previous smoke resistant partitions were removed to ensure the hazardous areas were separated from other spaces appropriately. 2. Over 20 residents, staff and visitors have the potential to be affected. Smoke resistant partitions were immediately cut to an appropriate size in the attic access areas and the previous smoke resistant partitions were removed to ensure the hazardous areas were separated from other spaces appropriately. 3. The maintenance staff were educated on K-0321. The DPO or his designee will audit all attic access areas weekly for 6 weeks and until 100% compliance is achieved, then monthly for 6 months to ensure the smoke resistant partitions are separating the hazardous areas from other spaces appropriately. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	155546	A. BUILDING 01 B. WING	04/09/2025

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K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 1 of 26 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Beauty Shop. Findings include: Based on observations with the Administrator and the Director of Plant Operations (DPO) at 1:21 p.m. on 04/09/25, the wall mounted ABC type portable fire extinguisher installed in the Beauty Shop had missing monthly inspection documentation on the contractor affixed maintenance tag for the one month period of	K 0355	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were affected. The portable fire extinguisher identified as lacking proper documentation for inspection was immediately inspected. After inspection, the DPO immediately documented on the fire extinguisher tag the date and initials of the person performing the inspection. 2. Over 10 residents, staff and visitors in the vicinity of the Beauty Shop have the potential to be affected. 100% of all facility fire extinguishers were checked to ensure they had been inspected and that the inspection was properly documented. 3. The maintenance staff were educated on K-0355. The DPO or his designee will check all fire extinguishers bi-weekly for 6 weeks and until 100% compliance is achieved, then monthly for 6 months and until 100% compliance is maintained to ensure fire extinguishers do not lack proper documentation after inspection. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	04/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	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)			
K 0000 Bldg. 02	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: 04/09/25 Facility Number: 000565 Provider Number: 155546 AIM Number: 100267630 At this Life Safety Code survey, Bethel Pointe Health and Rehab 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). Building 01, consists of the existing one story	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.	

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	155546	A. BUILDING 02 B. WING	04/09/2025

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	building constructed in 1994 which 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. Building 01 was surveyed under Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. Building 02, constructed in 2019, is a one story facility and consists of new resident sleeping rooms 227 through 252 and a connecting hallway to the renovated Therapy Room and was determined to be of Type V (111) 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. Building 02 was surveyed under Chapter 18, New Health Care Occupancies and 410 IAC 16.2. The facility has a capacity of 114 and had a census of 107 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 04/10/25			