

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

PRINTED: 06/25/2025

FORM APPROVED

OMB NO. 0938-039

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____ | X3) DATE SURVEY COMPLETED 06/05/2025 |
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| NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP COD 1707 BETHANY RD ANDERSON, IN 46012 |
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| (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 |
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| E 0000 Bldg. -- | <p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 06/05/25</p> <p>Facility Number: 011045 Provider Number: 155698 AIM Number: 200380790</p> <p>At this Emergency Preparedness survey, Bethany Pointe Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.</p> <p>The facility has 74 certified beds. At the time of the survey, the census was 51.</p> <p>Quality Review completed on 06/09/25</p> | E 0000 | | |
| K 0000 Bldg. 01 | <p>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).</p> <p>Survey Date: 06/05/25</p> <p>Facility Number: 011045 Provider Number: 155698 AIM Number: 200380790</p> <p>At this Life Safety Code survey, Bethany Pointe Health Campus was found not in compliance with</p> | K 0000 | | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| Alicia Lambert | Area Executive Director | 06/23/2025 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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| K 0131 SS=E Bldg. 01 | <p>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.</p> <p>This one-story facility was determined to be of Type V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor, and hard-wired smoke detectors in the resident rooms. The facility has a capacity of 74 and had a census of 51 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 06/09/25</p> <p>NFPA 101 Multiple Occupancies</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 separation fire doors would limit the spread of fire and restrict the movement of smoke. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.4.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. This deficient practice could affect 25 residents.</p> <p>Findings include: Based on observations during a tour of the facility</p> | K 0131 | <p>Bethany Pointe Health campus– POC POC due: 6-20-25 Date of Compliance: 6/20/25 The submission of this plan of correction does not indicate and admission by Bethany Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Bethany Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary</p> | 06/20/2025 |

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| | <p>with the Director of Plant Operations, Senior Director of Plant Operations and Cooperate Facilities Management Support representative on 06/05/25 at 1:38 p.m., the double set of barrier doors separating the Assisted Living from the Skilled Nursing did not close and latch. This condition would not limit the spread of smoke from one side of the fire barrier to the other. The Director of Plant Operations acknowledged these barrier doors did not close completely and latch and stated they were new doors recently installed.</p> <p>This finding was acknowledged by the Director of Plant Operations at the time of discovery and again at the exit conference with the Director of Plant Operations, Executive Director, Senior Director of Plant Operations and Cooperate Facilities Management Support representative present.</p> <p>3.1-19(b)</p> | | <p>care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.</p> <p>K131 Multiple Occupancies – Fire Doors</p> <p>Education regarding proper closing and latching of barrier doors completed for all maintenance employees. Double set of barrier doors separating the Assisted Living from the Skilled Nursing repaired on 6/20/25. Up to 25 residents have the potential to be affected by the alleged deficient practice. As a measure of ongoing compliance, the DPO or designee to audit Assisted Living and Skilled Nursing barrier doors 2x weekly for 4 weeks, then 1x weekly for 4 weeks, then 2x monthly for 4 months or until 100% compliance is maintained. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until</p> | |

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| K 0226 SS=E Bldg. 01 | <p>NFPA 101 Horizontal Exits</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 3 horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficiency could affect 26 residents in 2 smoke compartments when occupied.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Plant Operations (DPO), Senior Director of Plant Operations and Cooperate Facilities Management Support representative on 06/05/25 at 1:41 p.m., the rated fire door set into the TCU unit was used as a horizontal exit and as a smoke barrier. When tested the doors failed to latch into the frame due to the doors rubbing against each other. Based on interview at the time of observation, the DPO stated the fire door set was not latching into the frame because the doors were warped and would need significant attention.</p> <p>This finding was acknowledged by the Director of Plant Operations at the time of discovery and again at the exit conference with the Director of Plant Operations, Executive Director, Senior Director of Plant Operations and Cooperate Facilities Management Support representative</p> | K 0226 | <p>100% compliance is maintained.</p> <p>Bethany Pointe Health campus– POC POC due: 6-20-25 Date of Compliance: 6/30/25 The submission of this plan of correction does not indicate and admission by Bethany Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Bethany Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. K226 – Horizontal Exits Education regarding proper closing and latching of horizontal exit fire doors completed for all maintenance employees. Exit fire door in question to be repaired on 6/30/25 . Up to 26 residents have</p> | 06/30/2025 |

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| K 0324 SS=E Bldg. 01 | <p>present.</p> <p>3.1-19(b)</p> <p>NFPA 101 Cooking Facilities</p> <p>Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of</p> | K 0324 | <p>the potential to be affected by the alleged deficient practice. As a measure of ongoing compliance, the DPO or designee to audit all horizontal exit fire door sets 2x weekly for 4 weeks, then 1x weekly for 4 weeks, then 2x monthly for 4 months or until 100% compliance is maintained. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.</p> <p>Bethany Pointe Health campus– POC POC due: 6-20-25 Date of Compliance: 6/20/25 The submission of this plan of correction does not indicate and admission by Bethany Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Bethany Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents</p> | 06/20/2025 |

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| | <p>maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 6 staff, and no residents.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Plant Operations (DPO), Senior Director of Plant Operations and Cooperate Facilities Management Support representative on 06/05/25 at 1:41 p.m., the range and wheeled eqiopment on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the DPO, on 06/05/25, at 1:55 p.m., the facility was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning.</p> <p>This finding was acknowledged by the Director of Plant Operations at the time of discovery and again at the exit conference with the Director of Plant Operations, Executive Director, Senior Director of Plant Operations and Cooperate Facilities Management Support representative present.</p> <p>3.1-19(b)</p> | | <p>in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.</p> <p>K324 – Cooking Facilities Education regarding NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, Section 12.1.2.3, Section 12.1.2.3.1 completed for all maintenance staff. Appropriate method was identified to ensure that the appliances were returned to an approved design location, and education complete to all maintenance and dietary staff on 6/20/25. No residents, and 6 staff have the potential to be affected by the alleged deficient practice. As a measure of ongoing compliance, the DPO or designee to audit for availability of approved method for wheeled equipment weekly for 2 months, then monthly for 4 months or until 100% compliance is maintained. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance</p> | |

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| K 0355 SS=D Bldg. 01 | <p>NFPA 101 Portable Fire Extinguishers</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the maintenance area was installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect staff in the maintenance area.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Plant Operations (DPO), Senior Director of Plant Operations and Cooperate Facilities Management Support representative on 06/05/25 at 1:40 p.m., an ABC portable fire extinguisher in the maintenance area was sitting on the floor and was unsecured. Based on interview at the time of observation, the DPO agreed the extinguisher was sitting on the floor, the bracket designed to support the extinguisher was missing from the wall.</p> <p>This finding was acknowledged by the Director of</p> | K 0355 | <p>Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.</p> <p>Bethany Pointe Health campus– POC POC due: 6-20-25 Date of Compliance: 6/16/25 The submission of this plan of correction does not indicate and admission by Bethany Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Bethany Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. K355 – Standard for Portable Fire Extinguishers</p> | 06/16/2025 |
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| K 0363 SS=E Bldg. 01 | <p>Plant Operations at the time of discovery and again at the exit conference with the Director of Plant Operations, Executive Director, Senior Director of Plant Operations and Cooperate Facilities Management Support representative present.</p> <p>3.1-19(b)</p> <p>NFPA 101 Corridor - Doors</p> <p>Based on observation and interview, the facility failed to ensure 1 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 20 residents.</p> <p>Findings include:</p> | K 0363 | <p>Education completed for all maintenance staff related to NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10. The alleged deficient practice was not in a resident care area, but could affect staff in the maintenance area. As of 6/16/25 the fire extinguisher identified sits securely on a hanger intended for the extinguishers. As a measure of ongoing compliance, the DPO or designee will audit all fire extinguishers monthly for proper placement monthly for 6 months or until 100% compliance is maintained. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.</p> <p>Bethany Pointe Health campus-- POC POC due: 6-20-25 Date of Compliance: 7/7/25 The submission of this plan of correction does not indicate and admission by Bethany Pointe Health Campus that the findings and allegations contained herein</p> | 06/16/2025 |

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| | <p>Based on observations during a tour of the facility with the Director of Plant Operations (DPO), Senior Director of Plant Operations and Cooperate Facilities Management Support representative on 06/05/25 at 1:10 p.m., the corridor door from the kitchen into the dining room on the 600 hall, failed to close and latch positively into the door frame. Based on interview at the time of the observations, the DPO agreed the aforementioned corridor door did not close and latch into the door frame because the hardware had been harvested to repair another door.</p> <p>This finding was acknowledged by the Director of Plant Operations at the time of discovery and again at the exit conference with the Director of Plant Operations, Executive Director, Senior Director of Plant Operations and Cooperate Facilities Management Support representative present.</p> <p>3.1-19(b)</p> | | <p>are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Bethany Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.</p> <p>K363 – Corridor Doors Education regarding proper closing and latching of corridor doors completed for all maintenance employees. Alleged deficient doors to be repaired to proper functioning on 7/7/25. Up to 20 residents and 2 staff have the potential to be affected by the alleged deficient practice. As a measure of ongoing compliance, the DPO or designee to audit all corridor doors 2x weekly for 4 weeks, then 1x weekly for 4 weeks, then 2x monthly for 4 months or until 100% compliance is maintained. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus</p> | |

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| K 0920 SS=E Bldg. 01 | <p>NFPA 101 Electrical Equipment - Power Cords and Extens</p> <p>1. 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 residents.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Plant Operations, Senior Director of Plant Operations and Cooperate Facilities Management Support representative on 06/05/25 at 1:40 p.m., in the salon two power strips were being used to power a hair dryers and curling irons (high power draw equipment).</p> <p>This finding was acknowledged by the Director of Plant Operations at the time of discovery and again at the exit conference with the Director of Plant Operations, Executive Director, Senior Director of Plant Operations and Cooperate Facilities Management Support representative present.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011,</p> | K 0920 | <p>Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.</p> <p>Bethany Pointe Health campus– POC POC due: 6-20-25 Date of Compliance: 6/10/25 The submission of this plan of correction does not indicate and admission by Bethany Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Bethany Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. K920 – Electrical Equipment – Power Cords and Extension Cords</p> | 06/10/2025 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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 |
|----------------------------|---|---------------|---|----------------------|
| K 0921 SS=F Bldg. 01 | <p>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 1 staff in the maintenance office.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Plant Operations, Senior Director of Plant Operations and Cooperate Facilities Management Support representative on 06/05/25 at 2:20 p.m., in the 100 hall attic an extension cord was being used. The DPO stated that the extension cord had been used during the winter to thaw pipes. Based on interview at the time of observation, the DPO acknowledged an extension cord was in use as described above.</p> <p>This finding was acknowledged by the Director of Plant Operations at the time of discovery and again at the exit conference with the Director of Plant Operations, Executive Director, Senior Director of Plant Operations and Cooperate Facilities Management Support representative present.</p> <p>3.1-19(b)</p> <p>NFPA 101 Electrical Equipment - Testing and Maintenanc</p> <p>Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE</p> | K 0921 | <p>Education regarding appropriate use of power cords and extension cords completed with contracted beautician. Power strips removed on 6/10/25. Up to 4 residents have the potential to be affected by the alleged deficient practice. As a measure of ongoing compliance, the DPO or designee to audit beauty salon for power strips weekly for 2 months, then monthly for 4 months or until 100% compliance is maintained. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.</p> <p>Bethany Pointe Health campus– POC POC due: 6-20-25 Date of Compliance: 6/23/25 The submission of this plan of correction does not indicate and admission by Bethany Pointe Health Campus that the findings</p> | 06/23/2025 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____ | X3) DATE SURVEY COMPLETED 06/05/2025 |
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| | <p>is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents.</p> <p>Findings include:</p> <p>Based on records review, interview and facility tour with the Director of Plant Operations (DPO) on 06/05/25 at 10:15 a.m. no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The DPO stated that PCREE such as nebulizers, oxygen concentrators, vital signs monitors, and other electrical medical equipment was present and in use at the facility.</p> <p>The DPO stated that the facility was aware that the PCREE was required to be tested but had not</p> | | <p>and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Bethany Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.</p> <p>K921 – Electrical Equipment – Testing and Maintenance Requirements</p> <p>Education regarding section 10.5.6.2 of NFPA 99 completed with all maintenance staff. PCREE testing completed on 6/23/25. All residents have the potential to be affected by the alleged deficient practice. As a measure of ongoing compliance, the DPO or designee to audit for proper PCREE documentation monthly for 6 months. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan</p> | |

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

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FORM APPROVED
OMB NO. 0938-039

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| | <p>gotten to it yet.</p> <p>This finding was acknowledged by the Director of Plant Operations at the time of discovery and again at the exit conference with the Director of Plant Operations, Executive Director, Senior Director of Plant Operations and Cooperate Facilities Management Support representative present.</p> <p>3.1-19(b)</p> | | <p>will be reviewed and updated as warranted and will continue until 100% compliance is maintained.</p> | | |