

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>011045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/07/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BETHANY POINTE HEALTH CAMPUS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1707 BETHANY RD ANDERSON, IN 46012</b>
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(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) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00413805 and IN00414518.</p> <p>Complaint IN00413805 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00414518- No deficiencies related to the allegations are cited.</p> <p>Survey date: August 7, 2023</p> <p>Facility number: 011045</p> <p>Residential Census: 47</p> <p>Bethany Pointe Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00413805 and IN00414518.</p> <p>Quality review completed August 10, 2023.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_