STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155698	A. BUILDING 00 B. WING	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHANY POINTE HEALTH CAMPUS	1707 BETHANY RD ANDERSON, IN 46012

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00420416. Complaint IN00420416 - Federal/state deficiencies related to the allegation are cited at F656. Survey dates: October 30 and 31, 2023. Facility number: 011045 Provider number: 155698 AIM number: 200380790 Census Bed Type: SNF/NF: 26 SNF: 33 Residential: 52 Total: 111 Census Payor Type: Medicare: 20 Medicaid: 23 Other: 16 Total: 59 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 9, 2023.	F 0000		
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia Lambert	Executive Director	11/21/2023

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
	155698	A. BUILDING 00 B. WING	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHANY POINTE HEALTH CAMPUS	1707 BETHANY RD ANDERSON, IN 46012

(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
	objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155698	A. BUILDING 00 B. WING	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHANY POINTE HEALTH CAMPUS	1707 BETHANY RD ANDERSON, IN 46012

(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
	(iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility failed to develop and implement a care plan for targeted behaviors for 1 of 3 residents reviewed for care plans. (Resident C) Findings include: The clinical record for Resident C was reviewed on 10/30/23 at 10:32 a.m. Diagnoses included depression, anxiety, encephalopathy, acute kidney failure, right bundle-branch block, paroxysmal atrial fibrillation, hemiplegia and hemiparesis, convulsions, and obsessive-compulsive disorder. Review of a "Point of Care History", dated 7/23/23-7/28/23, indicated on 7/25/23 at 5:17 a.m., CNA 1 charted the following: "Resident yelled at top of his lungs THE WHOLE night Cause [sic] other residents to be in and out of sleep. ...." Review of a written statement by CNA 1, dated 7/24/23, indicated Resident C had "screamed all night worse than normal". Review of a progress note, dated 7/25/23 at 5:15 p.m., indicated the resident was tearful. He did not like the care he received the night before, and was worried that no one would provide care the next time he had a request. Review of the facility self- reportable, dated 7/25/2023, indicated the resident's care plans were reviewed and updated as needed. Review of the resident's clinical record indicated a lack of a care plan or individualized interventions for targeted behaviors, such as yelling.	F 0656	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. 1 Resident C was affected by alleged insufficient practice. Resident C continues to reside at the memory care unit of health campus. Resident C has shown no psychosocial distress related to event. Care plan reviewed and updated for Resident C. 2 All residents have the potential to be affected by the alleged deficient practice. Social Services Director and assistant educated on developing and implementing care plans related to	11/28/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155698	A. BUILDING 00 B. WING	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHANY POINTE HEALTH CAMPUS	1707 BETHANY RD ANDERSON, IN 46012

(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
	During an interview on 10/31/23 at 11:12 a.m., the Administrator indicated Resident C had known behaviors, such as yelling out. The resident would become anxious if he did not get what he wanted right away, and yelled out. During an interview on 10/31/23 at 11:28 a.m., LPN 2 indicated Resident C liked "a lot of attention". The staff were aware of his yelling behaviors. CNA 1 was not available for interview during the survey. This citation relates to Complaint IN00420416.		target behaviors. 3 As a measure of ongoing compliance, the Director of Social Services (DSS) or designee will complete a 100% audit of behavioral care plans on all residents to ensure proper care plan related to target behaviors. Care plans related to target behaviors will be reviewed for accuracy 3x per week for 4 weeks, 3x a week for 3 months, then 2x a week for 2 months or until 100% compliance is maintained. 4 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.	