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	09/06/2023

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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00415137. Complaint IN00415137 - State deficiencies related to the allegations are cited at R0052. Unrelated deficiencies are cited. Survey dates: September 5 and 6, 2023 Facility number: 011045 Residential Census: 56 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 12, 2023.	R 0000	The submission of this plan of correction does not indicate an admission by Bethany Pointe 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. 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.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to implement interventions to prevent the elopement of a cognitively impaired resident (Resident B) by	R 0052	1. Resident B was affected by alleged insufficient practice. Resident B continues to reside at the Memory Care Assisted Living	09/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alexa Troutman	DHS	09/19/2023

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.

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	failing to secure the entrance codes to the secure doors. Findings include: The clinical record for Resident B was reviewed on 9/5/2023 at 9:09 a.m. Diagnoses included hypertension, heart failure, muscle weakness, difficulty in walking, dementia with other behavioral disturbance, chronic atrial fibrillation, and Parkinson's disease. Resident B was admitted on 1/13/2023 from another health care facility without a secured unit, due to exit seeking behaviors. A progress note, dated 8/7/2023 at 6:33 p.m., indicated the resident was seen at the front exit door pushing buttons on the key pad. When the resident realized they were being watched, they left the area of the door. A progress note, dated 8/12/2023 at 12:56 p.m., indicated the resident exited the facility without the knowledge of the staff and no supervision. During an interview on 9/5/2023 at 10:18 a.m., QMA 12 indicated after she witnessed the resident attempting to push in a code to open the door, she notified the Unit Director. During an interview on 9/5/2023 at 11:11 a.m., the Unit Director indicated he had been notified of the resident's attempt to open the exit door. He had been having talks with the resident and family about the possibility of a safe discharge plan. The immediate intervention put in place was to monitor the resident. During an interview on 9/5/2023 at 12:26 p.m., QMA 9 indicated she was assisting another		unit of health campus. Resident B has shown no psychosocial distress, pain, and no injury related to event. Resident B continues to participate in diversional activities per service plan. 2. All residents have the potential to be affected by the alleged deficient practice. All staff have been educated on proper implementation of interventions to prevent the elopement of a cognitively impaired resident. 3. As a measure of ongoing compliance, the Legacy Neighborhood Director (LND) or designee will complete a 100% audit of exit seeking behaviors on all residents to ensure proper implementation of interventions to prevent elopement 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.	

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	resident in the dining room and saw Resident B walking outside the facility through a window. QMA 9 instructed Housekeeper 7 to check the resident's room. The QMA exited the facility and found Resident B ambulating with a walker on the facility property. The resident was redirected back into the facility and placed on 15-minute checks. Review of an investigation summary, provided by the Administrator on 9/5/2023 at 9:24 a.m., indicated the resident entered the key code and exited the facility at 12:58 p.m. on 8/12/2023. The Administrator was called by QMA 9 while she was with the resident, outside, at 12:56 p.m. During an interview on 9/5/2023 at 3:32 p.m., the Administrator indicated the exact time the resident exited the facility was seen on a security video. The Administrator had reviewed the security video, however the video was no longer available for viewing. No further information was provided at the time of the interview. During a facility tour, on 9/5/2023 at 11:00 a.m., the front door was observed to be glass with a textured coating, to make seeing through it difficult. The key pad, located in the entry way from the outside, was visible from inside the facility (through the glass door). A sign, located above the key pad, indicated the code was the month and the year followed by an asterisk sign. This state residential finding relates to complaint IN00415137.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The			

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	responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

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	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to report in a timely manner, an allegation of resident to resident sexual abuse between a moderately cognitively impaired resident (Resident B) and a severely cognitively impaired resident (Resident C). Findings include: The clinical record for Resident B was reviewed on 9/5/2023 at 9:09 a.m. Diagnoses included hypertension, heart failure, muscle weakness, difficulty in walking, dementia with other behavioral disturbance, chronic atrial fibrillation, and Parkinson's disease. Resident B was assessed as moderately cognitively impaired with a Brief Interview for Mental Status Score (BIMS) of 11 out of 15. The clinical record for Resident C was reviewed on 9/5/2023 at 9:57 a.m. Diagnoses include Alzheimer's disease. Resident C was assessed as severely cognitively impaired with a BIMS of 1 out of 15. A progress note, dated 9/3/2023 at 11:28 p.m., indicated staff observed Resident B coming out of Resident C's room. During an interview on 9/5/2023 at 4:39 p.m., QMA 5 indicated she observed Resident B exiting Resident C's room. The QMA called for another staff member to escort Resident B back to his room while she checked on Resident C. When	R 0090	1. Resident B and C were affected by alleged insufficient practice. Resident B is currently at an inpatient psychiatric hospital stay. Resident C continues to reside at the Memory Care Assisted Living unit of health campus. Resident C has shown no psychosocial distress, pain, or injury related to the event. Resident B continues to participate in diversional activities per service plan. 2. All residents have the potential to be affected by the alleged deficient practice. Executive Director has been educated on reporting requirements of abuse. 3. As a measure of ongoing compliance, Executive Director (ED) or designee will review reportable submissions timeliness 2x per week for 4 weeks, weekly for 4 months, and 2x per month for 1 month or until 100% compliance is maintained. 4. As a quality measure, the Director of Health Services (DHS) 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	09/15/2023

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	QMA 5 entered Resident C's room she observed the resident in the bathroom with the door opened and lights on. The resident was standing over the toilet wearing a night gown and no brief. Review of a statement by QMA 13, dated 9/1/2023, the QMA indicated she asked Resident B if he had touched Resident C. Resident B indicated he had touched Resident C "from head to toe". The resident told QMA 13 he touched Resident C's private parts. During an interview on 9/6/2023 at 10:00 a.m., the Administrator indicated she had been informed of the incident on 9/1/2023 at 9:23 p.m. The Administrator was gathering facts to write the reportable, causing a delay. Review of the confirmation for reportable indicated the incident happened on 9/1/2023 at 9:15 p.m. The reportable was sent to the State agency on 9/2/2023 at 12:16 a.m., 2 hours and 48 minutes after the Administrator was made aware. Review of a current policy dated 2019 and last revised on June 2023 was provided by the Corporate Consultant on 9/5/2023 at 4:38 p.m., and titled "Abuse and Neglect Procedural Guidelines" indicated the following: " ....g/ Reporting/Response .... ii. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries off unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, ..."		100% compliance is maintained.	