

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 10/17/2025
NAME OF PROVIDER OR SUPPLIER Bethany Pointe Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1707 Bethany Rd Anderson, IN 46012	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to supervise a resident, who was identified as a risk for elopement, had a diagnosis of dementia, and resided on a secured dementia unit, from eloping through a secured code locked egress door, which was opened by a guest for 1 of 1 resident reviewed for elopement (Resident B). This deficient practice allowed the resident to be unaccounted for outside of the facility for approximately 50 minutes, where he walked across a four-laned highway and past a park, which contained trails, playground equipment, and a lake. He traveled approximately 0.7 miles, where he was seen by an employee, who was coming to work. He was then returned to the facility via car by said employee. The deficient practice was corrected on October 12, 2025, prior to the start of the survey, and was therefore past noncompliance. The immediate jeopardy began on 10/11/25 when Resident B left the facility unsupervised and walked approximately 0.7 miles toward a city park, placing him at risk for serious injury or death. Findings include: Resident B's clinical record was reviewed on 10/16/25 at 10:30 a.m. Current diagnoses included dementia with agitation, bradycardia, and mild neurocognitive disorder due to known physiological condition with behavioral disturbance. A hospital discharge note, dated 10/3/25, indicated the resident's goal at discharge was long term care rehabilitation and then potential placement on a memory care unit. During his stay in the hospital, he at times had extreme sundowning (increased agitation and confusion later in the day) and required physical restraints. The resident was admitted to the facility's healthcare unit on 10/3/25 and received rehabilitation services. A 10/3/25 Elopement Risk Assessment indicated the resident had a history of exit seeking, voicing statements of leaving, and exhibiting exit seeking behaviors. A physician's order was received on 10/3/25 for a wander alarm bracelet/device (a device which ensures doors lock when the wearing comes within range.) A 10/4/25 Brief Interview for Mental Status assessment indicated Resident B was severely cognitively impaired. Resident B had a 10/8/25 care plan problem/need regarding demonstrates exit seeking behaviors. Approaches to this need included: (10/8/25) apply wander guard to ankle and monitor as ordered, evaluate need for secured unit and transfer if needed, and monitor for wandering triggers. Progress notes related to wandering and/or the need for supervision included the following: 10/3/25 at 3:34 p.m.-Wander guard order received and device was placed on left ankle. 10/3/25 at 7:00 p.m.- Resident placed on 1:1 supervision for safety. Plan of care ongoing. 10/4/25 at 5:00 p.m.- Resident was one to one with staff this shift. 10/5/25 at 5:41 p.m.- Resident continued on one-to-one supervision. Resident believed his car was in the back parking lot. 10/6/25 at 5:07 a.m.- Resident remained on one-to-one supervision. 10/8/25 at 6:42 a.m.- One -to-one supervision continued. A 10/10/25 at 4:15 p.m. progress note indicated the resident would be moved to the secured dementia unit and the family agreed. The clinical record indicated the resident changed rooms from the health care building to the separate, secured dementia building on 10/10/25. Due to the unit being a secured locked, dementia unit, the wander alarm and one to one supervision were discontinued. A review of facility video camera footage for 10/11/25 from 1:35 p.m. to 1:36 p.m. showed a guest speaking with Resident B and another resident, then the visitor entered the keycode and held the door open to allow Resident B to exit the secured dementia unit. During an interview, on 10/16/25 at 1:38 p.m., CNA 6 indicated she had worked on the secured unit the day Resident B had eloped from the facility. The resident had asked the CNA how to get out of the unit's door. During an interview, on 10/16/25 at 2:23 p.m., CNA 5 indicated she had seen Resident B on the unit around 1:35 p.m. on the day he eloped from the facility. The guest who entered the code usually sat up toward the front of the building in the common area. During an interview on 10/16/25 at 2:02 p.m., QMA 4 indicated she had been driving to work on Saturday, 10/11/25, at approximately 2:25 p.m., when she saw Resident B walking on the sidewalk by the park just over the bridge past the boat launch. She immediately turned around and approached the resident. She offered him a ride back to the facility. He thanked her and indicated his legs were very tired. He indicated he had been walking to his daughter's house. He was wearing a T-shirt, sweatpants, house shoes, and a ball cap. She notified the dementia care director and the on-call supervisor to inform them she had found the resident and was returning him to the facility. They had not been aware the resident was missing. During an interview, on 10/16/25 at 2:15 p.m. Resident B was on his knees in his room and had moved the large wardrobe from the corner into the pathway of the door. The door was unable to open completely. The resident got up off his knees without any assistance or holding onto any furniture. He indicated he was searching for his missing wallet and telephone. He had placed them on top of the wardrobe</p>		