STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155698	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Pointe Health Campus	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure a resident, who had not been deemed able to self-administer medications, received supervision during a nebulizer medication administration for 1 of 1 resident (Resident C) randomly observed receiving a nebulizer treatment. Findings include:During a random observation, on 2/6/26 at 11:21 a.m., Resident C was laying in bed holding a nebulizer mask to her face. The nebulizer machine was in operation on the bedside table. No staff were present. On 2/6/26 at 11:25 a.m., CNA 7 entered the resident's room and indicated she was going to change her and get her up. CNA 7 left the resident's room and went down to the nurse's station. On 2/6/26 at 11:27 a.m., the MDS (Minimum Data Set) Coordinator entered Resident C's room and turned off the nebulizer machine. As she exited the resident's room, she indicated the resident's nurse was on break. She was not sure if the resident could self-administer her own nebulizer treatments and it depended on the resident's cognition. Resident C's clinical record was reviewed on 2/6/26 at 11:42 a.m. Diagnosis included unspecified dementia, unspecified severity, without behavioral disturbance. Current physician's orders included ipratropium-albuterol solution (breathing treatment medication) 0.5 mg (milligram) - 3 mg, administer 3 ml (milliliter) via inhalation for Chronic Obstructive Pulmonary Disease (COPD) three times daily. Her physician's orders lacked an order for self-administration of nebulization treatments. During an interview on 2/6/26 at 1:54 p.m., RN 17 indicated Resident C was not able to self-administer, but he normally allowed her to complete the nebulizer treatments without staff being present. The resident had been assessed as cognitively intact and she had use of her hands. Due to other medications needing completed, the nurse needed to prioritize. A Self-Administration of Medication assessment, with an observation date of 1/29/26 at 2:41 p.m. and completed on 2/6/26 at 2:45 p.m., indicated that it was appropriate for the resident to self-administer ipratropium-albuterol and the medication would be stored in the resident's room. The resident's progress notes and care plan lacked documentation related to self-administration for nebulization. During the Exit Conference on 2/9/26 at 1:03 p.m., the Nurse Consultant indicated, related to late entries, the facility had 14 days to enter the self-administration assessment into the resident's clinical record. A current facility policy, titled Specific Medication Administration Procedures, and provided by the DON on 2/9/26 at 12:20 p.m. indicated the following: .Nebulizer - Administering Medications through a Small Volume (Handheld) Nebulizer .L. Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer A current facility policy, titled Guidelines for Late Entry and Corrections to Medical Record, and provided by the Executive Director on 2/9/26 at 1:32 p.m. indicated the following: .Procedure . 2. Every effort should be made to record the information or event as soon as it is available or occurred. a. Late entries should be an exception, not the rule. 3. If information is obtained after the event or was forgotten to be recorded the entry should be noted as a Late Entry a. The late entry should reflect the current date and time of entry as well as the date and time the event occurred or information was obtained .5. Late entries to the (continued on next page)

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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record should be completed within 14 days 3.1-47(a)(6)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented to mitigate the risk of contamination when a staff member failed to perform hand hygiene and change gloves after performing perineal care and subsequently placed soiled linens on the floor during 1 of 3 observations of resident care (Resident F).Findings include:During an observation of resident care, on 2/6/26 at 1:58 p.m., Resident F was laying in bed. CNA 8 and QMA 25 applied gloves and uncovered the resident. The resident's incontinence brief was soiled. QMA 25 provided perineal care, removed the soiled brief from under the resident, retrieved a trash can located near the bathroom door, and placed the soiled brief in the trash can. CNA 8 and QMA 25 assisted the resident with dressing, assisted the resident to sit on the side of the bed, and assisted the resident into a wheelchair. QMA 25 removed the resident's oxygen tubing from the bag hanging on the wheelchair and assisted the resident in applying the nasal cannula to their face and nose. While CNA 8 was making the resident's bed, she placed a soiled bath blanket onto the carpeted floor. CNA 8 indicated that the bath blanket was soiled a small amount and she would not normally place soiled linens on the floor. QMA 25 indicated he had forgotten to change his gloves and would normally change his gloves after providing perineal care.Resident F's clinical record was reviewed on 2/9/26 at 10:56 a.m. Diagnoses included Parkinson's disease without dyskinesia, without mention of fluctuations, and dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance. A 1/23/26 quarterly Minimum Data Set (MDS) assessment indicated that he was moderately cognitively impaired. He was dependent for toileting hygiene and required substantial to maximal assistance with personal hygiene. He was always incontinent of bladder and frequently incontinent of bowel.During the Exit Conference, on 2/9/26 at 1:03 p.m., the Executive Director indicated that they did not have a policy related to changing gloves after providing perineal care.A current facility policy, titled Guidelines for Handling Linens, provided by the DON on 2/9/26 at 12:20 p.m. indicated the following: Procedure .Dirty Linen .4. Do not place soiled linen on furniture or floor This citation relates to Intake 2729658. 3.1-18(b)(1)