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	05/13/2025

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

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 42685 Based on record review and interview, the facility failed to provide bed hold policy notifications to the resident and/or their representative for 2 of 2 residents reviewed for hospitalization s. (Resident 30 and 53) Findings include: 1. During an interview on 5/6/25 at 4:25 p.m., Resident 30 indicated he was sent out for a hospitalization approximately one month ago. The facility did not provide him with any bed hold paperwork. Resident 30's clinical record was reviewed on 5/7/25 at 1:43 p.m. Diagnoses included heart failure, fluid overload, and pneumonia. A 2/19/25, admission, Minimum Data Set (MDS) assessment indicated Resident 30 was cognitively intact. A 3/27/25, discharge, MDS assessment indicated the resident discharged with a return anticipated. Review of a notice of transfer/discharge form, dated 3/27/25, indicated Resident 30 was discharged to the hospital. The form indicated the facility must attach a copy of the facility's bed hold policy. The clinical record lacked a bed hold notice or indication it was offered to the resident. A nurse's note, dated 3/27/25 at 4:14 p.m., indicated all appropriate documentation was sent with emergency personnel. A nurse's note, dated 3/28/25 at 8:53 a.m., indicated the resident was admitted to the hospital for acute respiratory failure and chronic obstructive pulmonary disease exacerbation. 2. Resident 53's clinical record was reviewed on 5/7/25 at 4:21 p.m. Diagnoses included nonrheumatic aortic valve stenosis, pulmonary hypertension, and acute post-hemorrhagic anemia. A 12/26/24, admission, Minimum Data Set (MDS) assessment indicated Resident 53 was cognitively intact. A 1/3/25, discharge, MDS assessment indicated the resident discharged with a return anticipated. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a notice of transfer/discharge form, dated 1/3/25, indicated the resident was discharged to the hospital. The form indicated the facility must attach a copy of the facility's bed hold policy. A nurse's note, dated 1/3/25 at 12:56 p.m., indicated the notice of transfer and bed hold forms were completed. The clinical record lacked indication of who received the bed hold form. During an interview on 5/12/25 at 11:50 a.m., RN 6 indicated the notice of transfer form and the bed hold policy were usually given to the resident and the emergency personnel when a resident was discharged to the hospital. The information was required to be documented in the resident's progress notes. During an interview on 5/12/25 at 4:29 p.m., LPN 4 indicated the notice of transfer form and the bed hold policy were provided to the emergency personnel to be taken to the hospital when a resident was sent out to the hospital. Copies were not provided to anyone else. All of the information regarding a discharge was required to be documented in the progress notes of the resident's clinical record. She was unaware of any other place in which the information was documented. During an interview on 5/13/25 at 9:48 a.m., the Administrator indicated both Resident 30 and Resident 53's clinical record did not have the bed hold policy attached to the notice of transfer/discharge. During an interview on 5/13/25 at 10:22 a.m., the DON indicated the bed hold policies were not in Resident 30 and Resident 53's clinical record because she threw them in the trash when she scanned the notice of transfer/discharge into the residents' clinical records. A current facility policy, revised on 11/18/16, titled Bed Hold Policy, provided by the Executive Director on 5/12/25 at 2:18 p.m., indicated the following: POLICY . The campus will properly inform residents in advance of their option to make bed-hold payments as well as the amount of the facility's charge to hold a bed . PURPOSE . To establish a policy and procedure following state and federal guidelines as it pertains to resident notification 3.1-12(a)(6)(A)(i)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48146 Based on observation, interview, and record review, the facility failed to ensure a resident with cognitive impairment was provided supervision and not left unattended while awaiting a medical appointment for 1 of 2 residents reviewed for supervision to prevent accidents. (Resident 25) Finding includes: During an interview on 5/7/25 at 10:56 a.m., Resident 25's family member indicated her loved one, who required supervision due to dementia, was transported by the facility transport to the hospital in mid-April for a scheduled medical procedure. The resident was left at the hospital without facility or family supervision. The resident's family became aware because a family friend saw the resident at the hospital waiting area and spoke to one of the resident's children. The family members acted quickly and got a family member to the location to stay with the resident during her medical procedure. The resident being unsupervised greatly concerned the family because she did not make safe choices. Had the resident been feeling better, this could have been a serious matter. The family member expressed their concern with the facility. The facility indicated they had believed a family member was meeting the resident at the appointment. Resident 25's clinical record was reviewed on 5/8/25 at 9:26 a.m. Current diagnoses included, Alzheimer's disease, anxiety, depression, and psychotic disturbance. A 4/26/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired and had Alzheimer's disease. A current 4/29/24, care plan problem/need indicated the resident had impaired or reduced safety awareness due to dementia. The goal for this problem was the resident will remain safe and not injure self secondary to impaired decision making. Approaches to this problem/need included: Determine if decisions made by the resident endanger the resident or others. Intervene if necessary (4/29/24), and observe for exit seeking behaviors, wandering into unsafe areas and entering other resident rooms un-invited (4/29/24). A current, 4/19/24, care plan problem/need indicated the resident was at risk of elopement. Approaches to this problem/need included redirect away from doors/exit as needed (4/19/24) and monitor for wandering triggers (4/19/24). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/25 at 3:39 p.m., the Transport Driver indicated he had transported Resident 25 to the hospital for testing on 4/11/25. He had been informed by one of the leaders of the dementia unit, he did not remember which one, that the resident's family would meet the resident at the hospital. When he arrived at the designated area of the hospital, the receptionist called the resident by name and said something about her family meeting her there. He did not see or speak to a family member. He left the resident there to chat with the receptionist and left to provide transportation to another resident. When he arrived back later that day to pick the resident up following the appointment, the family was there and he had no idea there had been any problem. When a family member was not scheduled to meet a resident at an appointment, either he or a CNA stayed with the resident. He was aware he was not to leave residents without a representative there. During this trip, the receptionist calling the resident by name and talking about family coming made him feel he was leaving them safe until the family arrived. Review of a facility Grievance Log entry dated 4/11/25, provided by the Administrator on 5/8/25 at 1:52 p.m., indicated Resident 25's family had called to express a concern that their loved one had been left at an appointment without a family member present to supervise them. The grievance indicated the driver was educated to never leave a memory care resident at any appointment if their family had not arrived. The form indicated the grievance was resolved on the same date. During observations on 5/6/25 at 10:56 a.m. and 5/7/25 at 9:36 a.m., Resident 25 was seated in an activity on the secured dementia unit. During an interview on 5/9/25 at 9:57 a.m., the Administrator indicated the facility did not have a policy regarding transportation of residents.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48146 Based on observation, interview, and record review, the facility failed to ensure residents who received psychoactive medications had gradual dose reductions or statements of clinical contraindication and had identified and documented targeted behavioral systems for the use of psychotropic medications for 2 of 5 residents reviewed for unnecessary medication. (Residents 13 and 34) Findings includes: 1. Resident 13's clinical record was reviewed on [DATE] at 9:22 a.m. Current diagnoses included delusional disorders, chronic diastolic (congestive) heart failure, morbid (severe) obesity due to excess calories, and obstructive sleep apnea. Current medication orders included sertraline (an antidepressant) 100 milligrams (mg) give one tablet daily ([DATE]), quetiapine (an antipsychotic) 25 mg give one tablet at bedtime ([DATE]), and trazodone (an antidepressant) 50 mg give one tablet at bedtime ([DATE]). A [DATE], pharmacy Consultant Report recommended a dosage reduction for either the trazodone 50 mg or Seroquel 25 mg, as both had been in place since [DATE]. The medications were used for sleep and hallucination/delusions at nighttime. The report indicated to please evaluate symptoms and determine if a trial gradual dose reduction is appropriate. If a gradual dose reduction was clinically contraindicated, please document resident specific rationale to continued dosing. The physician response to this recommendation was marked as I decline. Written on the response to recommendation line was Continue as ordered. The form lacked a statement of contraindication that included a risk-benefit analysis. A current care plan, dated [DATE], indicated Resident 13 demonstrated altered behaviors including hallucinations. Interventions included medications as ordered ([DATE]), monitor residents mood, affect, and behavior during care ([DATE]), and redirect as needed ([DATE]). A current care plan, dated [DATE], indicated the resident demonstrated altered behaviors including delusions. Interventions included medications as ordered ([DATE]), monitor residents behavior during care ([DATE]), and observe for behavioral triggers and causal relationships to medical changes ([DATE]). The resident's care plans lacked identified targeted behaviors, including delusions or hallucinations for the use of antipsychotic medications and targeted symptoms for the use of an antidepressant medication. Review of the resident's medication administration record for [DATE] to [DATE] indicated targeted behaviors were marked at the end of each shift with delusions having occurred eight (8) times and hallucinations having occurred twelve (12) times over the three (3) month period. The documentation lacked resident-specific delusions and/or hallucinations. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A [DATE] nurse practitioner progress note indicated the resident had severe obstructive sleep apnea and was not compliant with the use of a continuous positive airway pressure (CPAP) machine which to led to episodes of hypercapnia (too much carbon dioxide in the blood stream), hallucinations, and an increased heart rate. This had led to delusions and hospitalization . The resident had responded nicely to quetiapine 25 mg at night and to continue the sertraline 75 mg daily as the residents anxiety had been stable. The resident would be appropriate for reduction at the next recommendation. A [DATE], quarterly, Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment, had no hallucinations, delusions, or behaviors, and a gradual dose reduction of antipsychotic medication had not been attempted since the previous assessment. On [DATE] at 11:01 a.m., Resident 13 was seen fully dressed and self propelling her wheel chair down the hallway. On [DATE] at 10:55 a.m., Resident 13 was seated on the edge of the bed. She indicated she was sleepy and had just woken up. On [DATE] at 11:39 a.m., Resident 13 was lying in bed, crying. She indicated she was feeling sad and would let the staff know if she needed any assistance. On [DATE] at 9:36 a.m., Resident 13 was calmly lying in bed watching television. During an interview on [DATE] at 3:01 p.m., CNA 7 indicated Resident 13 had mentioned seeing children in her room and feeling anxious. The resident was easy to redirect. During an interview on [DATE] at 3:09 p.m., the Infection Preventionist indicated Resident 13 reported seeing people, especially children running around her room and tried to talk to them. During an interview on [DATE] at 3:11 p.m., LPN 9 indicated Resident 13 had talked about hearing and seeing children in her room. During an interview on [DATE] at 3:15 p.m., the DON indicated Resident 13 had seen bugs on her windows, blinds and floor. Resident 13 talked to children not present in her room. The resident's hallucinations tended to come and go, and were not consistent. The resident went periods of time without any complaints or concerns. The DON indicated she was aware the resident's clinical record did not have specific information or documentation related to the hallucinations and delusions. 2. Resident 34's clinical record was reviewed on [DATE] at 11:49 p.m. Diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, need for assistance with personal care, and essential (primary) hypertension. Current medication orders included amitriptyline (an antidepressant) 10 mg give one tablet at bedtime ([DATE]), duloxetine (an antidepressant) 60 mg give one table at bedtime for depression ([DATE]), and quetiapine (an antipsychotic) 25 mg, give one tablet at bedtime ([DATE]). Previous medication orders, discontinued on [DATE], included amitriptyline 10 mg, give one tablet in the morning and one tablet at bedtime ([DATE]), and quetiapine 25 mg give one-half tablet at bedtime ([DATE]). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A [DATE] pharmacy Consultant Report indicated Resident 34 received multiple medications that were due for a dosage reduction evaluation: duloxetine 60 mg at bedtime, amitriptyline 10 mg at bedtime, and quetiapine 12.5 mg in the morning and 25 mg at bedtime. The report indicated to please evaluate signs and symptoms of depression and delusions and determine if a trial gradual dose reduction is appropriate at this time. If the dose reduction was clinically contraindicated, please document resident specific rationale. The physician response to this recommendation was marked as I decline. Written on the response to recommendation line was risk outweighs benefit. The form lacked a statement of contraindication that included a risk-benefit analysis. A current care plan, dated [DATE], indicated Resident 34 demonstrated altered behaviors including delusions, for example the family was not there. Interventions included medications as ordered ([DATE]), monitor resident's behaviors with all care ([DATE]), and psych services as needed ([DATE]). A current care plan, dated [DATE], indicated the resident presented with diagnoses of delusional disorder, depression, and anxiety. Interventions included medications as ordered ([DATE]), observe mood, affect, and behaviors with care ([DATE]), and titrate medication to the lowest effective dose ([DATE]). The resident's care plans lacked identified targeted behaviors, delusions, or hallucinations for the use of the antidepressant or antipsychotic medications. Review of the resident's medication administration record for February 1, 2025 to February 28, 2025 indicated targeted behaviors were marked at the end of each shift with delusions having occurred eleven (11) times during the month. The documentation lacked resident-specific delusions. A [DATE], annual, Minimum Data Set (MDS) assessment indicated Resident 34 had severe cognitive impairment and had not experienced hallucinations, delusions, or behaviors. A [DATE], nurse practitioner progress note indicated to continue medications for delusional disorder and depression. Continue to monitor mood, appetite, and sleep patterns. On [DATE] at 10:51 a.m., Resident 34 was seated calmly in her wheel chair near the end of her bed. On [DATE] at 10:53 a.m., Resident 34 was lying quietly in bed facing the window. On [DATE] at 11:40 a.m., Resident 34 was lying in bed and indicated she was sleepy as she had stayed awake late watching some television. On [DATE] at 9:40 a.m., Resident 34 was lying quietly in bed watching the television. During an interview, on [DATE] at 3:01 p.m. CNA 7 indicated Resident 34 has not mentioned experiencing any hallucinations or delusions recently. On [DATE] at 3:09 p.m., the Infection Preventionist indicated Resident 34 had packed up her belongings thinking she was going to be moving soon. The resident would try to take the belongings of her room mate. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:11 p.m., LPN 9 indicated Resident 34 had not mentioned feeling anxious or having any hallucinations or delusions. On [DATE] at 3:13 p.m., the DON indicated Resident 34 would complain of seeing small children in her room and needing to go help her parents, whom are both deceased . The resident experienced most of her delusions in the evening. She was aware the resident's clinical record did not have specific information or documentation related to the hallucinations and delusions. Resident 34's daughter was very involved with her care and had previously refused to accept gradual dose reductions in July and November of 2024. The medical director and the DON had spoken with the daughter and explained the need for trial dose reductions and was able to get the daughter to allow the medication changes made in the current month of May. A facility policy, revised [DATE], titled, Psychotropic medication use and gradual dose reduction guidelines, provided by the DON on [DATE] at 10:24 a.m., indicated the following: .To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team . 1. Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process .4. Efforts to reduce dosage or discontinue psychotropic medications will be ongoing, as appropriate. 5. A gradual dose reduction (GDR) will be attempted for two (2) separate quarters (with at least one month between attempts) per the physician's recommendation. Gradual dose reduction must be attempted annually thereafter, unless medically contraindicated. 6. Gradual dose reductions will be documented on the appropriate event in the EHR 3XXX,d+[DATE](a) 3XXX,d+[DATE](b)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 48146 Based on record review and interview, the facility failed to offer and educate residents regarding pneumococcal vaccines per the Center for Disease and Control (CDC) guidance for 2 of 5 residents reviewed for infection control. (Resident 17 and 18) Finding includes: 1. Resident 17's clinical record was reviewed on 5/7/25 at 1:40 p.m. Diagnoses included unspecified dementia with other behavioral disturbances, unspecified injury of head, subsequent encounter, and hypertension. The admitted was 5/10/23. A 3/14/24, significant change, Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment. Review of the resident's vaccinations included the following: The resident had a historical administration of Pneumovax 13 (pneumococcal) on 11/16/16, prior to admission to the facility. A Pneumococcal Vaccine Consent Form, dated 5/10/23, indicated the resident was provided education and declined administration. The clinical record lacked any other offerings of the Pneumococcal vaccine since 2023. 2. Resident 18's clinical record was reviewed on 5/8/25 at 12:38 p.m. Diagnoses included unspecified paraplegia, elevated white blood cell count, and neuromuscular dysfunction of the bladder. The admitted was 4/4/22. A 3/8/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. Review of the resident's vaccinations included the following: The resident had a historical administration of Pneumovax 13 on 9/29/20, prior to admission to the facility. A Pneumococcal Vaccine Consent Form, dated 4/4/22, indicated the resident was provided education and declined administration. The clinical record lacked any other offerings of the Pneumococcal vaccine since 2022. During an interview, on 5/12/25 at 11:01 a.m., the Infection Preventionist indicated she offers the Influenza, COVID-19, and Pneumococcal vaccinations on admission. The facility utilized consent/declination forms for the vaccinations offered. She only offered the Influenza and COVID-19 vaccinations annual thereafter. She indicated she followed the Center for Disease and Control (CDC) guidance. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy, revised 7/12/23, titled, Guidelines for Influenza, Pneumococcal, and COVID-19, provided by the Executive Director on 5/6/24 shortly after entrance conference, indicated the following: The purpose of this policy is to: To establish an immunization program that facilitates providing education to residents and resident representative allowing them to make an informed decision regarding immunization and to follow through per their decision to receive or not to receive immunization unless medically contraindicated .6. Each resident will be offered, unless medically contraindicated, or already vaccinated, a pneumococcal vaccine per attending physician's orders .12. Pneumococcal vaccinations per CDC recommendations . 3.1-18(b)(5)