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	10/17/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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. A10/3/25 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 (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 (taller than 6 feet). He indicated his family, and the workers were aware of the missing items but did not seem to care about finding them. He indicated he had not been outside in weeks because it's too muddy and he would not want to track in muddy footprints. He did not remember the incident where he left the building. He indicated he was in a hotel. He sat himself on the edge of his bed and stood up without assistance twice. He was fully dressed in sweats and a T-shirt with hard-soled slippers on and a baseball cap. His walker was against the far wall/window. During an interview on 10/16/25 at 2:38 p.m., the Administrator and DON indicated Resident B was assessed as an elopement risk at the time of admission, and a wander guard and one to one supervision were started. When a bed became available on 10/10/25, the resident was moved to the dementia unit. Resident B exited the facility on 10/11/25 when a regular guest/visitor entered the code and assisted the resident to exit. The facility became aware of the resident's exit when QMA 4 called to notify the facility that she had found him walking by the park. The facility used an internet mapping website to determine the park was approximately 0.7 miles from the facility. A facility self-reported incident, dated 10/11/25, indicated Resident B, who had a diagnosis of dementia, had exited the secured dementia unit and was found off the campus property by a staff member and had been returned to the facility. An Investigation Summary, dated 10/13/25, indicated on 10/11/25, the resident was seen by staff at 1:35 p.m. He was assisted to exit the facility by a visitor at 1:36 p.m. The resident was identified off campus by an employee at 2:20 p.m. (44 minutes after exiting the facility). At approximately 2:28 p.m., the resident was returned to the facility by the staff member who saw him. An observation on 10/16/25 at 4:16 p.m., indicated the facility's (Legacy) secured dementia unit's front door exited to a parking lot. The parking lot had two exit driveways. The closest exit drive ran up to the main entrance and exit and lead to [NAME] Road. [NAME] Road was a narrow, paved, tree-lined road which had a steep decline down to the highway. The road did not have a sidewalk. The exit from the facility to the road had limited visibility which was impeded by the trees, tall weeds, and wildflowers. The road was approximately one block from a four-laned highway (Scatterfield Road/Indiana 9). The corner where [NAME] Road meets the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	highway had steady traffic and a posted speed limit of 45 miles an hour. The intersection had a stop light. All directions driven from the facility to the park did not have any visible sidewalks. The sidewalk began at the park itself. For each direction driven, the distance from the facility to the park was just short of one mile. A current facility policy, dated 12/17/24, titled Guideline for Elopement/Missing Resident, which was provided by Administrator 2 on 10/16/25 at 10:35 a.m., indicated: Disoriented Residents (already deemed an elopement risk) observed exiting the campus door: a. Attempt to prevent the departure and redirect. c. Be courteous in preventing the departure. This deficient practice was corrected by 10/12/25 after the facility implemented a systemic plan that included the following actions: education of staff and visitors related to elopement risks and maintaining the integrity of the secured unit's egress doors, new signage was implemented, residents were assessed for elopement risk, and quality assurance activities were developed to mitigate risk of recurrence. This tag relates to Intake 26422578. 3.1-45(a)