STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155546	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Pointe Health and Rehab	3400 W Community Dr Muncie, IN 47304

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure a staff member spoke to a resident in a dignified and respectful manner for 1 of 5 residents observed during medication administration. (QMA 15 and Resident E) Findings include:During a medication observation, on 6/17/26 at 11:52 a.m., QMA 15 prepared medication for Resident E and entered the resident's room. Resident E sat in her wheelchair, holding baby doll. QMA 15 approached the resident with the medication and indicated she had her medicine and asked the resident if she wanted to show how big of a girl she was by taking her medication. QMA 15 attempted to administer the resident's medication and the resident pulled back. QMA 15 attempted again, and the resident took the spoon. QMA 15 guided the resident's hand holding the spoon to her mouth. After the resident took the medication QMA 15 stated Look at her, she's a big girl, good job.During an interview, on 6/17/26 at 12:04 p.m., QMA 15 indicated she spoke to the resident in a childlike manner because that was how the resident responded. During an interview with the Administrator present, on 6/17/26 at 12:57 p.m., the DON indicated Resident E was care planned for having a baby doll and speaking to the doll as though it were a real person.Resident E's clinical record was reviewed on 6/18/26 at 8:31 a.m. Diagnoses included severe intellectual disabilities and aphasia.A 3/25/26 quarterly Minimum Data Set assessment indicated she was rarely/never understood.A current 10/4/21 care plan indicated the resident preferred to have her baby doll or stuffed dog with her daily. She had difficulty communicating at times and responded best to questions with yes or no answers.A current 12/12/25 care plan indicated she had a communication deficit as evidenced by severe intellectual disability and she was generally non-verbal. Her interventions included she would be able to effectively communicate her wishes by gestures such as shaking her head yes or no (12/12/25) and responded best to questions requiring yes/no responses (12/12/25).A current facility policy, dated 11/29/23 and titled Promoting/Maintaining Resident Dignity, provided by the Administrator on 6/17/26 at 1:34 p.m. indicated the following: .Compliance Guidelines: 1. All staff member are involved in providing care to residents to promote and maintain resident dignity and respects resident rights. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(a)

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview and record review, the facility failed to ensure medications were administered according to facility policy to prevent medication errors and failed to ensure medications were prepared and administered according to physician orders and facility policy for oral and inhaled medications. (Residents C, B, F, and E) Findings include:1.A 5/23/26 anonymous intake submitted to the Indiana Department of Health (IDOH) indicated a resident had been administered medications intended for another resident, resulting in hospitalization.Resident C's clinical record was reviewed on 6/17/26 at 10:28 a.m. Diagnoses included essential (primary) hypertension, acute on chronic diastolic (congestive) heart failure, obstructive and reflux uropathy, and dizziness and giddiness.His medications included buspirone (treat anxiety) 5 mg, paroxetine (treat depression) 40 mg, quetiapine (antipsychotic) 12.5 mg, and tramadol (opiate pain medication) 100 mg.A progress note, dated 5/22/26 at 10:32 p.m., indicated Resident C was administered baclofen (muscle relaxer) 10 mg, melatonin (treat insomnia) 5 mg, levetiracetam (treat seizures) 1000 mg, quetiapine 300 mg in addition to routine medications. He had no allergies to the medications. He was alert and oriented, and at his baseline. Vitals were obtained, and the on-call physician ordered to monitor vital signs every two hours, implement enhanced fall precautions, and to report any decline in condition.An SBAR (Situation, Background, Assessment, and Recommendation) note, dated 5/23/26 at 2:50 a.m., indicated the resident exhibited jumbled speech, inability to form a sentence, hallucinations, and a blood pressure of 86/54 millimeters of mercury (mm Hg). Orders were received to send him to the emergency room for an evaluation and treatment. A nurses note, dated 5/23/26 at 9:45 a.m., indicated the resident returned to the facility from the emergency room following an evaluation for a medication error resulting in lethargy and worsening vital signs. A new order was received to hold his metoprolol for one day. He was transferred from transport cart to bed without awakening and continued to appear sedated/lethargic.A nurses note, dated 5/23/26 at 2:50 p.m. indicated he had a decline in condition following return from the emergency room. He remained nonresponsive and was not able to be aroused to verbal and tactile stimuli. He had intermittent periods of apnea (breathing stopped) lasting approximately 15-20 seconds with gurgling respirations. He had urinary retention and had not voided in over 12 hours. A bladder scan was performed showing approximately 660 milliliters of urine. A new order was received to send him to the emergency room for further evaluation and treatment.A nurses note, dated 5/23/26 at 8:10 p.m., he returned from the hospital with a new order for cephalexin (antibiotic) and a urinary catheter.During an interview, on 6/17/26 at 1:20 p.m. QMA 33 indicated, on 5/22/26, it had been busy, and she was stressed and flustered. She knocked over a medication cup while preparing Resident D's medication, and pills spilled on top of the medication cart and two fell on the floor. She placed the two pills from the floor and the pills from the top of the medication cart back into the medication cup. When she looked at the MAR (Medication Administration Record), it displayed Resident C's name, and she got confused and thought that she was preparing Resident C's medication. She prepared and placed Resident C's medication in the cup that was intended for Resident D. She administered Resident D's medication and Resident C's medication to Resident C between 9:30 p.m. and 9:45 p.m. About five minutes later, she realized she had given Resident C and Resident D's medication to Resident C. She immediately reported the error to the nurse.2.During the initial tour of the facility, on 6/17/26 at 9:21 a.m., Resident B was observed sitting on the side of her bed receiving a nebulizer treatment via mask without licensed staff present. CNA 17 entered Resident B's room, assisted her with a pillow behind her back, and exited the room.At 9:26 a.m., RN 24 entered Resident B's room, removed the nebulizer, and checked her oxygen saturation. RN 24 indicated that her oxygen level was low, and applied oxygen via nasal cannula. RN 24 exited Resident B's room. During an interview at the time of the observation, RN 24 indicated the resident's oxygen saturation was 90% but came up to 94%. Resident B had orders for oxygen but refused to wear it. Resident B did (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not have an order to self-administer her nebulizer treatment and RN 24 would normally stay with the resident during the treatment. Resident B's clinical record was reviewed on 6/17/26 at 9:36 a.m. Diagnoses included unspecified dementia, acute respiratory failure with hypoxia (low oxygen level), and COPD (chronic obstructive pulmonary disease).Current orders included ipratropium-albuterol solution (bronchodilator) 3 ml (milliliters), inhale 3 ml orally daily to be administered by a clinician.A Social Services Assessment and Plan, dated 6/15/26, indicated she had moderate cognitive impairment.Her clinical record lacked a self-administration assessment.3. During a medication administration, on 6/18/26 at 9:10 a.m., RN 24 obtained Resident F's blood pressure, pulse, and oxygen saturation level. RN 24 prepared Resident F's medication and entered his room. After administering his pills, she removed his T-piece nebulizer from the plastic bag hanging on his overbed table and placed the contents of a vial of ipratropium-albuterol solution into the chamber. She handed the resident the nebulizer and turned on the nebulizer machine. Once the treatment was completed, she took the nebulizer from his hand and returned it to the plastic bag. RN 24 exited the resident's room and began preparing another resident's medication.During an interview, on 6/18/26 at 9:38 a.m., RN 24 indicated she had not yet listened to Resident F's breath sounds and she normally placed the nebulizer in the plastic bag.Resident F's clinical record was reviewed, on 6/18/26 at 10:11 a.m. Diagnoses included COPD with (acute) exacerbation.Current orders included ipratropium-albuterol solution 3 ml, inhale 3 ml orally four times daily, breath sounds chart C for clear, W for wheezes, D for diminished, CR /F for fine crackles, and CR/C for coarse crackles (Respiratory treatment) four times daily.4. During the medication observation, on 6/17/26 at 11:52 a.m., QMA 15 indicated Resident E received nectar thick liquids. QMA 15 poured 17 grams of polyethylene glycol powder (treat constipation) into an 8-ounce medication cup, filled the cup one-quarter full (approximately 60 ml) of nectar thick water and stirred. She administered the resident's pills and then administered the polyethylene glycol through a straw.Resident E's clinical record was reviewed on 6/18/26 at 8:31 a.m. Diagnoses included constipation and dysphagia.Current orders included polyethylene glycol powder 17 grams daily and to dissolve in fluids.During an interview, on 6/17/26 at 12:04 p.m., QMA 15 indicated she did not remember the required amount of fluid for polyethylene glycol administration and would guess it to be 280 ml. She indicated the less water used was better because the resident did not like water. After checking the label of the polyethylene glycol bottle, QMA 15 indicated there was supposed to be eight ounces (240 ml) of water added to the polyethylene glycol.On 6/18/26 at 11:45 a.m., the Administrator provided QMA 33, RN 24, QMA 15's education on medication administration, each dated 5/22/26.A current facility policy, reviewed on 11/11/24, titled Medication Administration, provided by the Administrator, on 6/18/26 at 11:45 a.m., indicated the following: Policy Explanation and Compliance Guidelines.10. Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage.11. Review MAR to identify medication to be administered.17. Administer medication as ordered in accordance with manufacturer specifications. a. Provide appropriate amount of food and fluid.A current facility policy, revised 8/25/25, titled Nebulizer and Aerosol Generating Procedure Therapy, provided by the Administrator on 6/17/26 at 1:34 p.m. indicated the following: .Procedure.4. Stay with the resident during delivery of the medication unless the resident has been deemed appropriate to self-administer by the IDT (Interdisciplinary Team) and has an order to self-administer.9. Listen to lung sounds with a stethoscope. (Include in assessment: Sp02, heart rate, respiratory rate, and post treatment evaluation.).12. Disassemble the nebulizer and T-piece and rinse with tap water. Reassemble nebulizer and place in plastic bag that is clean and dated. This citation relates to Intake 3022941. 410 IAC (Indiana Administrative Code) 16.2-3.1-14(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record reviews, the facility failed to ensure a medication cart was not left unlocked and unattended for 2 of 5 medication administration observations (North Medication Cart) and medication was not left unattended on top of a medication cart for 2 of 5 medication administration observations. (Center Medication Cart) Findings include:1. On 6/17/26 at 11:52 a.m., QMA 15 prepared medication for Resident E. She walked down the hall and administered the medication in the resident's room while leaving the North Hall medication cart unlocked and unattended at the nurse's station.At 12:04 p.m., QMA 15 returned to the unlocked cart. During an observation, accompanied by QMA 15, the medication cart contained eye drops, prefilled insulin pens, insulin needles, lancets, prepackaged medication, nebulizer vials, nose spray, antacid medication, liquid and powdered medication. During the observation, QMA 15 indicated that she normally locked the cart when she walked away from it but she was nervous and accidentally forgot to lock it.2. On 6/18/26 at 9:30 a.m., RN 24 prepared medication for Resident G. She indicated the omeprazole (treat stomach acid) 20 mg (milligram) and bupropion (treat depression) 150 mg from the prepackaged pack were discontinued and were not on the resident's medication administration record. She placed the pills back in the package, wedged the side of the package under a box of gloves located on top of the medication cart and entered the resident's room and closed the door.At 9:38 a.m., RN 24 returned to the medication cart. She indicated she would not normally leave the medication unattended on top of the medication cart. On 6/18/26 at 11:45 a.m. the Administrator provided QMA 15 and RN 24's skills competency reviews that indicated the following:On 5/23/26 and 6/8/26, the DON performed a medication skill competency related to medication pass procedure and included locking the medication cart for QMA 15.On 5/22/26 and 6/8/26, the DON performed a medication skill competency related to medication pass procedure and included returning container/card to proper area in cart for RN 24.A current facility policy, revised 4/16/24, titled Medication Storage, provided by the Administrator on 6/18/26 at 1:34 p.m. indicated the following: . General Guidelines: a. All drugs and biologicals will be stored in locked compartments.c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. This citation relates to Intake 3022941. 410 Indiana Administrative Code (IAC) 16.2-3.1-25(m)