

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER Bethel Pointe Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to ensure wound treatments were implemented and consistently completed to promote healing for 2 of 4 residents reviewed for wound care. (Resident B and Resident E) This deficient practice resulted in delayed treatment for a chronic wound to Resident B's toe that was later surgically amputated. Findings include: 1. Resident B's clinical record was reviewed on 7/13/26 at 9:24 a.m. Diagnoses included type 2 diabetes mellitus with foot ulcer, other osteomyelitis, unspecified sites, skin graft (allograft) (autograft) infection, non-pressure chronic ulcer of other part of left foot with unspecified severity, peripheral vascular disease, local infection of the skin and subcutaneous tissue, and acquired absence of other toe(s), unspecified side. A cytology hospital surgical report, dated 6/16/26, indicated he had a left first toe and left first metatarsal excision (removal/amputation). A hospital discharge report, dated 6/27/26, indicated to start linezolid (antibiotic) 600 milligram (mg) twice daily through 7/27/26, metronidazole (antifungal) 500 mg twice daily through 7/27/26, thiamine (supplement) 100 mg daily, folic acid (supplement) 1 mg daily, and nitroglycerin paste to the amputation site. The Wound Vacuum Assisted Closure (VAC) dressings were to remain clean, dry, and intact until the resident's first follow-up appointment. An admission assessment, dated 6/27/26, indicated he had a surgical incision to his left toe(s) and his dressing to his left foot was intact, clean and dry. The wound nurse was to follow the resident. A 6/29/26 surgical wound care plan indicated he had complications related to diabetes and infection. His interventions included treatment as ordered (6/29/26). A 6/29/26 care plan indicated he had an infection in his surgical graft wound due to bacteria/osteomyelitis. Interventions included applying his treatment(s) as ordered (6/29/26). A 6/30/26 revised care plan indicated he had two surgical wounds with failed grafts. Interventions included staff would apply his treatment as ordered (6/29/26). A nurses note, dated 6/29/26 at 10:35 a.m., indicated a new skin issue to his left dorsum first digit amputation site, six staples were present, there was increased exudate (drainage) and an odor. A nurses note, dated 6/29/26 at 1:36 p.m., indicated an order was received to cleanse the left foot surgical site with wound cleanser and pat dry. Apply moist to dry dressing to site, cover with super absorbent dressing, change twice daily and as needed. He was to have appointment with the wound clinic on 6/30/26. An initial wound evaluation and management summary, dated 7/2/26, indicated the resident had a post-surgical wound of his left medial foot. A new order was given for the primary dressing of calcium alginate (wound treatment) with silver daily and as needed, and a secondary dressing for gauze sponge and gauze wrap for 30 days. And he had a diabetic wound to his (now remaining) first toe on his left foot. His (now remaining) first toe was described as intact with purple/maroon discoloration. A new order was given for betadine (antiseptic) daily and as needed for 30 days. The July Treatment Administration Record (TAR) lacked the new 7/2/26 wound care orders. A nurses note, dated 7/8/26 at 9:27 a.m., indicated the second digit on his left foot was dark in color. The wound center was notified, and orders were received for a surgical evaluation appointment on (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 155546 If continuation sheet Page 1 of 3

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F 0684 Level of Harm - Actual harm Residents Affected - Few	7/14/26. A wound evaluation and management summary, dated 7/9/26, indicated the resident was seen for a post-surgical wound of his left medial foot. New orders included leptospermum honey (medical grade honey for wound treatment) daily and as needed for 30 days, to continue alginate calcium with silver daily and as needed for 23 days. He was also seen for a diabetic wound of his left foot, first toe and it was described as 100% thick adherent devitalized necrotic (dead) tissue and to continue the order for betadine daily and as needed for 23 days. His July TAR lacked the new and continued wound treatment orders. On 7/13/26 at 1:16 p.m., Resident B was sitting in a wheelchair. He had an elastic bandage around his left foot that was slightly loose at the back of his heel. The resident indicated the treatment to his left foot had not been completed for three days. He was experiencing anxiety related to whether or not he was having surgery the next day. He indicated that his toe was black as the ace of spades, and started after he admitted to the facility. On 7/13/26 at 1:27 p.m., Wound Nurse 6 indicated the wound doctor had already been into the facility and Resident B's treatment had already been completed. On 7/13/26 at 1:30 p.m., LPN 17 indicated, after observing Resident B's dressing, it did not look like his treatment had been completed. During a wound care observation for Resident B, on 7/13/26 at 4:07 p.m., Wound Nurse 6 indicated that she had already changed the dressing to his left foot. The tape on the elastic bandage was dated 7/13/26 at 2:00 p.m. A nurses note, dated 7/14/26 at 2:54 p.m., indicated the nurse practitioner spoke with the nurse at the wound center and indicated that the resident was sent to the emergency room for a STAT (immediate) surgery for the amputation of his left foot second toe. During an interview, on 7/14/26 at 10:45 a.m., Wound Nurse 6 indicated she completed resident wound care treatments Monday through Friday. She completed rounds with the wound doctor on Mondays and Thursdays. The wound doctor gave verbal orders during wound rounds, and they communicated with one another during the week. The wound doctor's progress notes were scanned into the electronic health records automatically. She was not sure who reviewed the wound doctor's progress notes, but thought that the Unit Manager may review them. Resident B admitted to the facility on a Friday or Saturday after the amputation of his great toe, and she saw him on the first Monday he was there. The Wound Nurse received the order for the wound cleanser wash on 6/29/26 from the hospital and the order should not have been discontinued on 7/1/26. She normally looked at the orders but did not catch that it was discontinued. Resident B's second toe on his left foot was noticed on 7/8/26 and a wound appointment was made. A Peripherally Inserted Central Catheter (PICC) line was placed, and he received Intravenous (IV) antibiotics for a wound infection. A culture was obtained and they were awaiting the results. 2. Resident E's clinical record was reviewed on 7/13/26 at 12:17 p.m. Diagnoses included paraplegia, stage 4 (full thickness wound exposing all skin layers down to underlying muscle, bone, or tendon) pressure ulcer of right buttock, and non-pressure chronic ulcer of the back with unspecified severity. A 4/29/26 revised care plan indicated she had a stage 4 pressure ulcer to her spine. Interventions included she would receive her treatment as ordered (2/27/26). A 4/29/26 revised care plan indicated she had a stage 4 pressure ulcer to her right ischial tuberosity (lower part of pelvis that supports body when seated). Interventions included she would receive her treatment as ordered (4/29/26) June 2026 TAR orders included the following: Cleanse right ischium with wound wash, pat dry apply calcium alginate to wound cover with super absorbent dressing secure with coverall, change daily and as needed. Cleanse the lower spine with wound wash, rinse with saline. pack with black foam to fit inside wound and run vacuum continuously at 150 millimeters of mercury (mmHG) change every Monday, Wednesday, Friday and as needed. The June 2026 TAR lacked documentation for completed treatments for her right ischium on 6/24, 6/25, and 6/30, and for her lower spine on 6/24. The July 2026 TAR lacked documentation for completed treatments for her right ischium on 7/1, 7/6, and 7/7, (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	and for her lower spine on 7/1 and 7/6. During an interview, on 7/14/26 at 10:45 a.m., Wound Nurse 6 indicated Resident E admitted to the facility with pressure ulcers and was currently on intravenous antibiotics for an infection to her wounds. An x-ray was completed and osteomyelitis (bone infection) was suspected. A wound culture was obtained, and they were awaiting the results. She normally completed her wound VAC treatment. She worked on the dates that lacked signatures on the MAR for June and July and the treatments were completed. The nurses documented the treatments after the Wound Nurse completed them. During an interview, on 7/14/26 at 11:37 a.m., LPN 14 indicated Wound Nurse 6 normally completed Resident E's treatments. Wound Nurse 6 would either tell her, or she would see her completing the treatments and she documented in the MAR when Wound Nurse 6 completed the treatments. During an interview, on 7/14/26 at 11:57 a.m. RN 22 indicated she asked Wound Nurse 6 if she completed the wound treatments or Wound Nurse 6 would tell her what to document. During an interview, on 7/14/26 at 1:34 p.m., Unit Manager 32 indicated she did not review the wound doctor's progress notes nor document the orders from him. Wound Nurse 6 completed rounds with the wound doctor and entered the treatment orders. When Wound Nurse 6 completed rounds she would tell the nurses that the treatments were completed and what the wound looked like and then the nurses would document it. During an interview, on 7/14/26 at 2:35 p.m., the DON indicated Wound Nurse 6 should document in the clinical record when she completed the treatments. A 12/21 revised current facility policy, titled Administrative Transcription of Physician's Orders, provided by the Administrator on 7/14/26 at 3:53 p.m., indicated the following: .admission Protocol or Return From Hospital Stay Within 15 Days.2. Transcription of physician order: a. Carefully, review transfer record and discharge summary from the hospital.c. After each order is entered in the Physician Order tab of the chart, check that ll orders were entered correctly.7. Medication and treatment orders are to be transcribed in the physician order tab of the electronic medical record. A 4/24 revised current facility policy, titled Following Physician Orders/Parameters, provided by the Administrator on 7/14/26 at 3:26 p.m., indicated the following: .Policy.8) After performing the activity, the licensed healthcare personnel will document administration and/or response to the procedure in the MAR or TAR. An undated current facility polity, titled Wound Treatment Management, provided by the Administrator on 7/14/26 at 3:12 p.m., indicated the following: .Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.7. Treatments will be documented on the Treatment Administration Record or in the electronic health record. This citation relates to Intake 4074283. 410 Indiana Administrative Code (IAC) 16.2-3.1-37(a)		