

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/21/2026
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 0726 Level of Harm - 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 interview and record review, the facility failed to ensure staff had the competencies and training to administer medication according to facility policy to prevent medications errors for 1 of 4 residents reviewed for medication administration (Resident B). This deficient practice resulted in Resident B's hospitalization in the intensive care unit for bradycardia (abnormally slow heart rate), hypotension (low blood pressure) and subsequent cardiogenic shock (heart cannot pump enough blood to meet the body's needs). Finding includes: Review of an Indiana Department of Health (IDOH) intake, submitted 7/16/26, indicated a resident had been hospitalized after he was administered medications intended for another resident. The staff member who administered the medication had made a similar medication error in the past month, which resulted in another resident requiring hospitalization. A hospital emergency department history and physical document, dated 7/16/26 at 12:52 p.m., indicated Resident B's history of present illness was an accidental overdose. Emergency medical services administered one milligram of atropine (for slow heart rate) due to the resident's heart rate being in the 30s enroute to the hospital. The resident received epinephrine (for slow heart rate when atropine and pacing are ineffective) 4 mg in 250 milliliters of 0.9 percent normal saline intravenously. The assessment included accidental ingestion of medication, bradycardia, and hypotension. His condition was described as guarded, and he was admitted to the intensive care unit (ICU). During an interview, on 7/20/26 at 12:34 p.m., the Director of Nursing (DON) indicated Qualified Medication Aide (QMA) 3 was suspended related to the medication error involving Resident B. QMA 3 had completed three medication administration in-services and one medication pass check-off since a prior medication error committed on 5/22/26. During an interview, on 7/20/26 at 1:31 p.m., the DON indicated she believed QMA 3 retrieved Resident C's medications and administered them to Resident B. Resident C's medications were stored adjacent to Resident B's medications in the medication cart. The medication packets had the residents' names listed on them, and she believed QMA 3 could not have checked the packets prior to preparing and administering the medications. Review of a facility document, titled Ad Hoc QAPI Form, dated 7/16/26, provided by the Administrator on 7/20/26 at 2:25 p.m., included the following: Summary of the Event: Resident B was given Resident C's medication by accident. Immediate Actions Taken: The QMA was immediately removed from passing medications and suspended pending investigation. Root Cause Analysis: Failure to correctly verify resident identification and medication packaging prior to medication administration during a hand-off of medication pass responsibilities. The nurse transferred responsibility for the final two residents' morning medication to the QMA while responding to another resident's care needs. At the time of the hand-off, medications for the two residents remained on the medication cart. The QMA selected the incorrect medication packet, prepared the medications, and administered them to the wrong resident. During interview, the QMA was unable to identify any environmental distractions, equipment issues, (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 0726 Level of Harm - Actual harm Residents Affected - Few	packaging defects, or other contributing factors that led to the error. The investigation determined that the QMA did not complete the required medication administration process, including confirming the resident name on the medication packet against the resident receiving the medications, prior to administration. Contributing factors included failure to follow the established rights of medication administration, specifically verification of the correct resident and correct medication prior to administration. No evidence indicated a packaging error, physician order error, transcription error, or equipment malfunction. The event was determined to be preventable and resulted from failure to adhere to established medication administration procedure. During an interview, on 7/20/26 at 2:08 p.m., QMA 3 indicated RN 4 was administering medications from the cart at the same time QMA 3 was attempting to administer medications to Resident B. QMA 3 did not verify the medications before administering them because RN 4 had another resident's medication administration record (MAR) open on the cart's electronic tablet. She should have taken 10 seconds to check both the MAR and the medication packets. She prepared and administered the medication, believing they belonged to Resident B, but they were Resident C's medications. She indicated she had been a QMA for two years without prior issues until recently and attributed the errors to not paying attention. During an interview, on 7/20/26 at 2:40 p.m., RN 4 indicated she had signed off the electronic tablet, provided the medication cart keys to QMA 3, and left to complete other tasks. She was not present at the cart during QMA 3's medication administration and discovered the error after finding Resident C's empty medication packets. During an interview, on 7/21/26 at 11:26 a.m., RN 5 indicated the MAR should always be checked against medications in the packets. She verified medication packets with the MAR and checked that she delivered the right medication to the correct person. During an interview, on 7/21/26 at 11:35 a.m., LPN 6 indicated she always verified with the MAR when administering medications. She worked on the rehabilitation unit and would often have a new resident tell her their name and date of birth as able, or the hospital armband if recently admitted. She paid close attention and verified the medication packets with the MAR. During an interview, on 7/21/26 at 2:05 p.m., RN 4 indicated when she administered medications, she reviewed the MAR, checked the resident name matched the MAR and the packet, and confirmed the pills in the packet matched the MAR. During an interview, on 7/21/26 at 2:12 p.m., RN 7 indicated when he passed medications, he opened the MAR, obtained the medication packet, checked each pill individually, ensured no additional or missing medications were present, and verified the name and room number on the packet matched the MAR. During an interview, on 7/21/26 at 3:35 p.m., the DON indicated she believed QMA 3 administered the wrong medications to Resident B. The DON had observed Resident C's empty medication packets on the day of the error. QMA 3 should have verified she was giving the right medication to the right person and followed the rights of medication administration. Review of the facility's 6/18/26 intake survey Statement of Deficiencies (2567) indicated the facility failed to ensure medications were administered according to facility policy to prevent medication errors when QMA 3 administered the incorrect medications to a resident, resulting in the resident requiring evaluation at the emergency department on 5/22/26 for lethargy and worsening vital signs. Review of QMA 3's facility in-service record indicated the following: On 5/22/26, QMA 3 received a review of the facility's medication administration policy. On 5/22/26, QMA 3 participated in a medication administration audit. On 5/22/26, QMA 3 attended an additional all-staff education regarding medication administration. On 6/25/26, QMA 3 attended an all-staff education regarding medication administration. A current facility policy, revised on 11/11/24, titled Medication Administration, provided by the Administrator, on 7/21/26 at 1:00 p.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. (continued on next page)		

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Right dosage.11. Review MAR to identify medication to be administered 12. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. Cross reference F760. This citation relates to Intake 3096409 and Intake 3097017. 410 IAC (Indiana Administrative Code) 16.2-3.1-48(c)(2)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review the facility failed to ensure a resident was free from a significant medication error for 1 of 1 resident reviewed for medication errors (Resident B). This deficient practice resulted in Resident B's hospitalization in the intensive care unit for bradycardia (abnormally slow heart rate), hypotension (low blood pressure) and subsequent cardiogenic shock (heart cannot pump enough blood to meet the body's needs). This deficient practice was corrected on 7/16/26, prior to the start of the survey, and was therefore past noncompliance. Findings include: Resident B's clinical record was reviewed on 7/20/26 at 11:49 a.m. Diagnoses included chronic respiratory failure with hypoxia, heart failure, anemia, iron deficiency anemia, essential (primary) hypertension, and Parkinson's disease without dyskinesia, with fluctuations. Current medications included aspirin 81 mg daily; nitrofurantoin monohydrate/macrocrystals (antibiotic) 50 mg daily at bedtime; hydrocodone-acetaminophen (opiate pain reliever) 5-325 mg twice daily; metoprolol tartrate (for high blood pressure) 12.5 mg twice a day; and carbidopa-levodopa (for Parkinson's) 25-100 mg, four tablets three times daily. An SBAR (Situation, Background, Assessment, and Recommendation) note, dated 7/16/26 at 10:30 a.m., indicated the resident was administered an amiodarone (for irregular heartbeat) 200 mg tablet, a citalopram (antidepressant) 10 mg tablet, a Certe Vite/Antioxidants (vitamin) tablet, a clopidogrel bisulfate (blood thinner) 75 mg tablet, a Floranex (probiotic dietary supplement) tablet, an omeprazole (decreases stomach acid production) tablet, an apixaban (blood thinner) 5 mg tablet, a buspirone (anxiety) 5 mg tablet, and a metoprolol 25 mg tablet. The resident also received a regular scheduled dose of hydrocodone-acetaminophen 5-325 mg. The resident was alert and oriented, at baseline, and exhibited no distress or complaints. The nurse practitioner (NP) ordered vital signs to be obtained every 30 minutes. The resident and his representative were notified. At 12:00 p.m., his vital signs were blood pressure 100/60 mm/Hg (millimeters of mercury), pulse 30 beats per minute, temperature 97.6 degrees Fahrenheit, and oxygen saturation was 92 percent on 2 liters of oxygen per nasal cannula. A new order was received from the NP directing that the resident be sent to the hospital for evaluation. A hospital emergency department history and physical document, dated 7/16/26 at 12:52 p.m., indicated the history of the present illness was an accidental overdose. Emergency medical services administered one milligram of atropine (for slow heart rate) due to the resident's heart rate being in the 30s enroute to the hospital. The resident received epinephrine (for slow heart rate when atropine and pacing are ineffective) 4 mg in 250 milliliters of 0.9 percent normal saline intravenously. The assessment included accidental ingestion of medication, bradycardia, and hypotension. His condition was described as guarded, and he was admitted to the intensive care unit (ICU). A hospital history and physical, dated 7/20/26, indicated Resident B had inadvertently been given another resident's medications prior to admission. In the emergency department, he was found to be bradycardic and hypotensive and was transferred to the ICU on intravenous epinephrine. The ICU team experienced difficulty in weaning him off the epinephrine, and the regimen was completed 7/19/26. His encephalopathy (malfunction of the brain that alters mental state) slowly improved, and he returned to baseline. He was stable for transfer to the hospitalist service (no longer required intensive care unit). The assessment and plan included: 1. Accidental overdose with subsequent cardiogenic shock, now improved; 2. cardiogenic shock, resolved; 3. Bradycardia, improving; and 4. toxic metabolic encephalopathy due to the above issues and urinary tract infection (UTI), improving with waxing and waning mentation. During an interview, on 7/20/26 at 12:34 p.m., the Director of Nursing (DON) indicated Qualified Medication Aide (QMA) 3 was suspended related to the medication error involving Resident B. QMA 3 had completed three (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	medication administration in-services and a medication pass check-off since a prior medication error committed on 5/22/26. RN 4 was on the nursing unit during the medication error on 7/16/26 and assisted with the reporting of it. Review of QMA 3's inservice record indicated the following: On 5/22/26, QMA 3 received a review of the facility's medication administration policy. On 5/22/26, QMA 3 participated in a medication administration audit. On 5/22/26, QMA 3 attended an all-staff education regarding medication administration. On 6/25/26, QMA 3 attended an all-staff education regarding medication administration. During an interview, on 7/20/26 at 1:31 p.m., the DON indicated Resident B received Resident C's medications on 7/16/26. RN 4 had asked QMA 3 to assist with completion of the morning medication pass for two residents (Resident B and Resident C). RN 4 wanted Resident C to receive her medications prior to leaving for an appointment. QMA 3 informed RN 4 that the medications for the pass were not present. Both RN 4 and QMA 3 searched through Resident C's entire roll of medication packets and were unable to find the morning packet. RN 4 then looked in the brown paper bag taped to the cart, which was used to dispose of the empty medication packets, and found Resident C's empty morning packets. They then realized Resident B's medications remained in the cart. The medication error was reported immediately to her DON, who became highly involved in monitoring and transferring Resident B to the hospital. The DON indicated Resident B's and Resident C's medication storage compartments were adjacent to each other in the medication cart. A review of the Medication Error Report, provided by the Administrator on 7/20/26 at 2:25 p.m., indicated on July 16 at 10:30 a.m., Resident B was given amiodarone 200 mg, citalopram 10 mg, CertiVite, clopidogrel bisulfate 75 mg, Floranex, omeprazole 40 mg, apixaban 5 mg, buspirone 5 mg, metoprolol 25 mg, and his scheduled hydrocodone-acetaminophen 5/325 mg. He was administered the wrong medications, experienced changes in vital signs, and was sent to the emergency department per physician order. The error was self-reported. QMA 3's handwritten statement, signed 7/16/26, and provided by the Administrator on 7/20/26 at 2:25 p.m., indicated QMA 3 assisted RN 4 with completing the morning medication pass. RN 4 asked her to pass Resident B's morning medications while RN 4 completed another medication pass. QMA 3 reached into the second drawer of the cart and retrieved what she believed were Resident B's medications. She removed his narcotic medication and indicated she had to move around frequently because RN 4 was also using the cart. She crushed the medications and administered them to Resident B. A few minutes later, when she attempted to administer Resident C's medication, she realized Resident C's morning medications were missing and notified RN 4. RN 4's printed text and undated, signed statement, provided by the Administrator on 7/20/26 at 2:25 p.m., indicated, at 10:10 a.m., QMA 3 arrived to assist with the medication pass. RN 4 had sent a resident to the hospital for chest pain and was running late with medication administration. Resident B's and Resident C's medications remained to be administered. Because Resident C was not in her room, RN 4 asked QMA 3 to give Resident B his medication. She signed out of the electronic tablet and provided QMA 3 the medication cart keys. RN 4 then went to the nurses' station. QMA 3 later sat down at the nurses' station, and RN 4 asked if Resident C had received her medication due to her upcoming appointment. QMA 3 searched for Resident C's medication and indicated she could not find it. Both RN 4 and QMA 3 were unable to locate the morning medication packets for 7/16/26. QMA 3 then indicated Resident B's 7/16/26 morning medication packet remained in the cart. RN 3 checked the brown paper bag containing empty medication packets and located Resident C's empty packets for that morning. RN 4 asked QMA 3 whether she had checked Resident B's medications before administering them. QMA 3 replied, Supposedly. RN 4 retrieved Resident C's morning medication list to find what medications were erroneously given to Resident B and told QMA 3 that Resident B's vital signs needed obtained. RN 4 immediately reported the medication error to her supervisor. During a phone (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	interview, on 7/20/26 at 2:08 p.m., QMA 3 indicated she arrived at the unit at 10:00 a.m. on 7/16/26. RN 4 directed her to assist with passing medications. RN 4 was still using the medication cart and had a resident's medication administration record (MAR) opened on the electronic tablet. QMA 3 did not check the MAR and acknowledged she committed another medication error. At 11:00 a.m., she checked Resident C's medications and realized they were missing. She indicated she should have paid more attention and could not believe that she had committed another medication error. She prepared and administered the medications, believing they were Resident B's, but administered Resident C's medications instead. During an interview, on 7/20/26 at 2:40 p.m., RN 4 indicated, around 10:10 a.m. on 7/16/26, QMA 3 arrived on the unit. RN 4 was running late due to addressing another resident's chest pain. RN 4 informed QMA 3 that two residents remained due for their morning medications. RN 4 signed out of the electronic tablet and handed QMA 3 the cart keys. RN 4 went to the nurses' station. QMA 3 later joined her at the nurses' station. RN 4 asked if Resident C had received her medication due to her appointment. QMA 3 left, then Resident C approached the medication cart setting in front of the nurses' station. QMA 3 asked RN 4 to look for Resident C's medication packet for that morning. RN 4 used the next day's morning medication packet for Resident C due to her appointment. QMA 3 then said Resident B's medication packet remained in the cart. RN 4 asked whether QMA 3 had checked Resident B's medications before administration, and QMA 3 replied, Supposedly. RN 4 located Resident C's empty morning medication packets in the brown bag and reported the error immediately to her supervisor. She did not pass medications at the medication cart at the same time as QMA 3. During an interview, on 7/21/2026 at 3:35 p.m., the DON indicated she observed Resident C's empty medication packets and believed QMA 3 mistakenly administered those medications, resulting in Resident B's subsequent hospital admission. A current facility policy, revised on 11/11/24, titled Medication Administration, provided by the Administrator, on 7/21/26 at 1:00 p.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 12. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. The deficient practice was corrected by 7/16/26 after the facility implemented a systemic plan that included the following actions: education of all working nurses and qualified medication aides on the Seven Rights of Medication Administration and minimizing distractions during a medication pass, observations of medication administration, and implementation of an ongoing quality improvement plan. Cross reference F726. This citation relates to Intake 3096409 and Intake 3097017. 410 IAC (Indiana Administrative Code) 16.2-3.1-48(c)(2)		