

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  03/21/2025
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)
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>42685</p> <p>Based on interview and record review, the facility failed to provide services for a resident with a feeding tube to prevent complications for 1 of 1 resident reviewed for tube feeding. (Resident 47)</p> <p>Finding includes:</p> <p>During an interview on 3/17/25 at 4:02 p.m., Resident 47 indicated she had a feeding tube as a result of a stroke. She recently began to have a pureed diet with thickened liquids for nutrition. She continued to receive her medications every day through her feeding tube.</p> <p>Resident 47's clinical record was reviewed on 3/18/25 at 2:29 p.m. Diagnoses included cerebral infarction without residual deficits, gastrostomy status, dysphasia, pharyngoesophageal phase, moderate protein-calorie malnutrition, and generalized muscle weakness.</p> <p>A current physician order, dated 2/20/25, indicated to change the enteral tube for splits/cracks in the tube, plugged, and/or dislodgement as needed.</p> <p>The clinical record lacked orders for gastrostomy tube site care.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 2/25/25, indicated the resident was cognitively intact. The resident required substantial assistance from staff for toileting, bathing, and lower body dressing. She required partial assistance from staff for transfers supervision for personal hygiene. Eating assistance from staff was marked not applicable. Nutritional approach included a feeding tube on admission and while a resident.</p> <p>A current care plan, dated 2/20/25, indicated the resident had a gastrostomy tube related to moderate protein calorie malnutrition. Interventions included, the resident will receive her feedings as ordered (2/20/25), observe the resident for any changes in breathing or increased coughing (3/4/25), check for placement of the feeding tube prior to administration of medications or feedings (3/4/25). The care plan lacked interventions for feeding tube site care.</p> <p>During an observation on 3/20/25 from 3:22 p.m. to 3:33 p.m., accompanied by LPN 6, the resident's feeding tube site had a clean and dry T-drain sponge in place, dated 3/20/25.</p> <p>(continued on next page)</p>

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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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview at the time of observation on 3/20/25 at 3:34 p.m., LPN 6 indicated the residents' clinical records with feeding tubes typically had an order for feeding tube site care every shift. She was unaware how to determine if site care had been performed every shift because she was unable to find the information in the resident's clinical record. It was the duty of every nurse to identify necessary orders and request orders that were lacking from the provider.</p> <p>During an interview on 3/21/25 at 12:42 p.m., Resident 47 indicated staff had not cleaned her feeding tube site and changed the dressing every shift ,nor every day. It had been cleaned intermittently, but she no longer received feedings through it.</p> <p>During an interview on 3/21/25 at 12:56 p.m., LPN 7 indicated Resident 47 was cooperative with her care. The clinical record for residents with feeding tubes typically included orders on the Treatment Administration Record (TAR) for feeding tube site care and T-drain sponge dressing changes. The orders provided prompts for nursing in the TAR when they were due. In the event a clinical record lacked an order for feeding tube site care, it was necessary to contact the provider for an order.</p> <p>During an interview on 3/21/25 at 1:17 p.m., the Corporate Nurse Consultant indicated a resident's tube site was assessed every day. The site would have been cleaned if it was dirty. The facility lacked information to show the resident's feeding tube site care had been performed. The clinical record lacked an order for feeding tube site care.</p> <p>A current facility policy, dated 11/27/23, titled Care and Treatment of Feeding Tubes, provided by the DON on 3/21/25 at 9:55 a.m., indicated the following: Policy: It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Policy Explanation and Compliance Guidelines: .3. The resident's plan of care will address the use of feeding tube, including strategies to prevent complications</p> <p>3.1-44(a)(2)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>42685</p> <p>Based on observation, interview, and record review, the facility failed to post complete nurse staffing information daily for residents and visitors. This deficiency had the potential to affect 103 of 103 residents in the facility.</p> <p>Finding includes:</p> <p>During an observation on 3/18/25 at 8:57 a.m., the facility nurse staffing for first shift, dated 3/18/25, was posted in a frame beside the restroom in the main hallway. The posting lacked the nurse staffing information for second and third shifts.</p> <p>Nurse staffing, dated 3/18/25, included the following:</p> <p>Census: 103</p> <p>Shift: 6:00 a.m. to 2:00 p.m.</p> <p>Registered Nurse: five staff at 8 hours = 40 actual hours</p> <p>Licensed Practical Nurse: eight staff at 8 hours = 64 actual hours</p> <p>Certified Nurse Aide: 9.5 staff at 7.5 hours = 71.25 actual hours</p> <p>During an observation on 3/18/25 at 4:28 p.m., the facility nurse staffing for first shift, dated 3/18/25, remained unchanged and posted in the hallway near the restroom. First shift ended at 2:00 p.m.</p> <p>During an observation on 3/19/25 at 1:09 p.m., the facility nurse staffing for first shift, dated 3/19/25, was posted in a frame beside the restroom in the main hallway. The posting lacked the nurse staffing information for second and third shifts.</p> <p>Nurse staffing, dated 3/19/25, included the following:</p> <p>Census: 99</p> <p>Shift: 6:00 a.m. to 2:00 p.m.</p> <p>Registered Nurse: four staff at 8 hours = 32 actual hours</p> <p>Licensed Practical Nurse: eight staff at 8 hours = 64 actual hours</p> <p>Certified Nurse Aide: ten staff at 7.5 hours = 75 actual hours</p> <p>During an observation on 3/19/25 at 3:11 p.m., the nurse staffing sign remained unchanged. First shift ended at 2:00 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 3/20/25 at 9:32 a.m., the facility nurse staffing for first shift, dated 3/20/25, was posted in a frame beside the restroom in the main hallway. The posting lacked the nurse staffing information for second and third shifts.</p> <p>Posted nurse staffing, dated 3/20/25, included the following:</p> <p>Census: 98</p> <p>Shift: 6:00 a.m. to 2:00 p.m.</p> <p>Registered Nurse: four staff at 8 hours = 32 actual hours</p> <p>Licensed Practical Nurse: eight staff at 8 hours = 64 actual hours</p> <p>Certified Nurse Aide: nine staff at 7.5 hours = 67.5 actual hours</p> <p>During an observation on 3/20/25 at 4:00 p.m., the nurse staffing sign remained unchanged. First shift ended at 2:00 p.m.</p> <p>During an observation along with the DON on 3/21/25 at 9:55 a.m., the facility nurse staffing for first shift, dated 3/21/25, was posted in a frame beside the restroom in the main hallway. The posting lacked the nurse staffing information for second and third shifts. During an interview at the time of observation, the DON indicated the second and third shift postings were in behind the first shift posting and not visible for residents and visitors. The nurse staffing was not posted in any other locations. Typically, they changed the nurse staffing posting at the beginning of each shift. She was unaware it had not been changed each day at the beginning of each shift 3/18/25 through 3/20/25. When nurse staffing posting was not changed at the beginning of each shift, one could not determine how many staff were on duty for the specific shifts.</p> <p>Posted nurse staffing, dated 3/21/25, included the following:</p> <p>Census: 101</p> <p>Shift: 6:00 a.m. to 2:00 p.m.</p> <p>Registered Nurse: four staff at 8 hours = 32 actual hours</p> <p>Licensed Practical Nurse: eight staff at 8 hours = 64 actual hours</p> <p>Certified Nurse Aide: nine staff at 7.5 hours = 67.5 actual hours</p> <p>(continued on next page)</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>A current facility policy, last revised 8/21/2024, titled Nurse Staffing Posting Information, provided by the DON on 3/21/25 at 12:22 p.m., indicated the following: Policy: It is the policy of this facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. Policy Explanation and Compliance Guidelines: 1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility name b. The current date c. Facility's current resident census d. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses ii. Licensed Practical Nurses/Licensed Vocational Nurses iii. Certified Nurse Aides 2. The facility will post the Nurse Staffing Sheet at the beginning of each shift. 3. The information posted will be: a. Presented in a clear and readable format. b. In a prominent place readily accessible to residents, and visitors</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48146</p> <p>Based on observation and interview, the facility failed to ensure insulin (a medication to treat diabetes mellitus) vials and pens were dated when opened and disposed of when expired for 2 of 5 carts reviewed for medication storage. (East and Center hall carts)</p> <p>Finding includes:</p> <p>1. During a medication storage observation of the East hall cart, accompanied by RN 4 on [DATE] at 10:58 a. m., the following was observed:</p> <p>One open vial of Glargine (long-acting) insulin, undated; the vial contained approximately 90 units, and</p> <p>One open vial of Lispro (short-acting) insulin, dated [DATE], [DATE] and [DATE]; the vial contained approximately 80 units.</p> <p>During an interview at the time of the observation, RN 4 indicated the East hall cart provided medications for eight diabetic residents, and insulin was good for 28 days from opening.</p> <p>During an interview, at the time of the observation, the DON indicated the insulin with three dates was misdated and if the staff were unsure of the open date on insulin, it would need to be disposed of properly.</p> <p>2. During a medication storage observation of the Center hall cart, accompanied by LPN 5 on [DATE] at 11:16 a.m., the following was observed:</p> <p>One open Lantus (long- acting) Solostar insulin pen, undated; the pen contained approximately 220 units, and</p> <p>One open vial of Lispro insulin, with illegible markings, the vial contained approximately 50 units.</p> <p>During an interview, at the time of the observations, LPN 5 indicated the Center hall cart provided medications to 5 diabetic residents. The insulin was good for 28 days from opening and if it the open date was illegible the insulin would not be appropriate to provide to a resident and would need to be disposed of.</p> <p>During a follow-up interview, on [DATE] at 11:13 a.m., the DON indicated the expectation for staff was insulin was to be dated when opened. This date was to be reviewed with each dose of insulin given to ensure the medication was not given after the 28 day expiration.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current facility policy, revised ,d+[DATE] and titled Labeling of Medications and Biological's, provided by the DON on [DATE] at 2:26 p.m., indicated the following: All medications and biological's used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications .2. Medication labels must be legible at all times .8. Labels for multi-use vials must include: a. The date the vial was initially opened or accessed (needle-punctured); b. All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial .</p> <p>A current facility policy, revised ,d+[DATE] and titled Product Expiration Dates, provided by the DON on [DATE] at 2:26 p.m., indicated the following: . Insulin vials expire 28 days after opening . Insulin pens expire at manufacturers date unless opened and then 28 days .</p> <p>3XXX,d+[DATE](j)</p> <p>3XXX,d+[DATE](k)</p>