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	02/13/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a physician's order for wound treatment in a timely manner and failed to implement physician's orders promptly to promote healing of a diabetic ulcer for 1 of 3 residents reviewed for skin conditions. (Resident 5) Findings include: Resident 5's clinical record was reviewed on 2/11/26 at 11:00 a.m. Diagnoses included primary hypertension, type 2 diabetes mellitus, and generalized muscle weakness.A current, 1/13/26, pressure ulcer care plan indicated Resident 5 had a stage 3 (full-thickness pressure injury) wound to the right lateral foot. Interventions included the following: treatment as ordered (1/13/26), report signs/symptoms of infection such as increased redness, warmth, induration at or near wound edges, foul odorous drainage (1/13/26), and initiate pain care plan interventions (1/13/26).A 1/21/26, admission, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired and had a stage 3 pressure injury.A 1/31/26 readmission Evaluation assessment indicated Resident 5 had a right lateral diabetic foot ulcer.A 2/1/26 Skin Issues assessment indicated Resident 5 had a right lateral foot pressure ulcer upon admission. The wound was 0.83 centimeters(cm) length (L) x 0.62 cm width (W) with 100% slough (soft white or yellow nonviable tissue), and light serosanguineous (thin, watery, and light red or pink) drainage. The treatment was listed as follows: generic wound cleanser, an antimicrobial dressing, and a composite dressing.A 2/2/26 readmission Skin Observation note indicated Resident 5 had a right lateral foot pressure area. The dressing was clean, dry, and intact.A 2/4/26 Daily Skilled Progress note indicated Resident 5 had a diabetic ulcer, without drainage.A 2/4/26 Weekly Skin Observation note indicated Resident 5 had a right lateral foot pressure area with a dry and intact dressing.A 2/6/26 wound center note indicated Resident 5 had a diabetic ulcer to his right lateral foot acquired on 1/3/25. The wound was 0.6 cm (L) x 0.7 cm (W) x 0.1 cm (D). The treatment was as listed as follows: Cleanse wound to right foot with Vashe (wound cleanser), pat dry, apply a slightly moist with saline Prisma (a collagen wound dressing) dressing and cover with a dry dressing and wrap with gauze once daily, every Monday, Wednesday, and Friday for wound healing.A 2/8/26, Daily Skilled Progress note indicated Resident 5 had a diabetic ulcer without drainage.A 2/11/26, Skin Issues assessment indicated Resident 5 had a stage 3 pressure ulcer to the right lateral foot on admission. The wound was 0.64 cm (L) x 0.8 cm (W) with 10% eschar (dead tissue), and light serous (clear watery fluid) drainage. The treatment was listed as follows: generic wound cleanser, Prisma, foam, and a compression wrap.Current treatment orders, dated 2/11/26, indicated to cleanse wound to right foot with Vashe (wound cleanser), pat dry, apply a slightly moist with saline Prisma (a collagen wound dressing) and cover with a dry dressing and wrap with gauze once daily, every Monday, Wednesday, and Friday for wound healing.The clinical record lacked an active wound treatment order from 1/31/26 - 2/11/26. During a wound observation, on 2/12/26 at 3:23 p.m., the Wound Nurse removed Resident 5's dressing from his right lateral foot. The dressing was dated 2/11/26. The wound was circular, pale, and white, with a raised border. The wound was roughly the size of a jumbo #2 yellow pencil eraser. There was no drainage present.During an interview, at the time of the observation, the Wound Nurse indicated this resident had a pressure ulcer to his right lateral foot. He had recently returned from a hospital stay and was seen at the wound (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	center on 2/6/26 and had returned with a wound treatment order. She indicated she had forgotten to enter the treatment order until the evening of 2/11/26. Treatment orders should be obtained and started immediately or as soon as possible when a wound was identified.During an interview, on 2/13/26 at 11:45 a.m., the DON indicated that when a resident admitted or returned to the facility, the nurse should complete a skin assessment. The nurse should document any skin conditions or wounds and contact the physician to obtain an order for treatment. The nurse should enter any orders and implement the treatment. Resident 5 should have had a treatment order upon his return to the facility. The nursing staff should follow all physicians' orders as given.A current facility policy, implemented 11/29/23, titled, Skin Integrity-Foot Care, provided by the DON on 2/13/26 at 10:17 a.m., indicated the following: .It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. This policy pertains to maintaining the skin integrity of the foot.1a. The facility will utilize a systemic approach for the prevention and management of [NAME] ulcers, including efforts to identify risk: stabilize, reduce, or remove underlying risk factors; monitor the impact of the interventions; and modify the interventions as possible. 2a. Licensed nurses will conduct pressure injury risk assessments and skin assessments in accordance with facility policy for those assessments.3c. Evidence-based treatment will be provided for all residents who have a foot ulcer.i. Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, or diabetic ulcers.5a. The attending physician will be notified of the presence, progression towards healing, or lack of healing of any foot ulcers, or any changes in a resident's medical condition. b. Interventions will be modified in a resident's plan of care as needed. 3.1-37(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow enhanced barrier precautions (EBP) during high contact care activities for a resident with an indwelling medical device for 1 of 4 residents reviewed for EBP. (Resident 47) Findings include:Resident 47's clinical record was reviewed on 2/11/26 at 3:19 p.m. Diagnoses included presence of left artificial knee joint, infection and inflammatory reaction due to internal left knee prosthesis, and disruption of external operation (surgical) wound.Current physician's orders included: Enhance Barrier Precautions (EBP) due to PICC (peripherally inserted central catheter) line and history of MRSA/VRE (Methicillin-Resistant Staphylococcus Aureus/Vancomycin-Resistant Enterococci) (antibiotic resistant bacteria), daptomycin (antibiotic) 500 milligram one time a day for knee joint infection, and non-weight bearing to left lower extremity.A current care plan, revised on 2/9/26, included the following: I require enhanced barrier precautions related to PICC line and history of MRSA/VRE. Interventions included: Staff will follow enhanced barrier precautions with my care as needed and you will provide my treatments as ordered.A 2/9/26 nurse's note indicated new orders were received from the physician to initiate enhanced barrier precautions related to PICC line and history of MRSE/VRE.During a random observation on 2/9/26 at 2:40 p.m., EBP signage was located on the right side of Resident 47's doorway. The signage read as follows: Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin opening requiring a dressing. A personal protective equipment (PPE) cart was also observed to the right of her bedside.During a dressing change observation on 2/12/26 at 1:37 p.m., the Wound Nurse performed hand hygiene prior to entering Resident 47's room. She indicated EBP was not required for this dressing change because the site was a closed surgical wound. She donned gloves and removed the resident's knee immobilizer (during which her jacket brushed against the right edge of the resident's bed and the resident's left bare thigh). Hand hygiene was performed and new gloves were donned, the area was cleaned, and a new dressing was applied (during which her jacket again brushed against the right side of the resident's bed, left thigh, and shirt). RN 4 removed the gloves and, with her bare hands, replaced the resident's knee immobilizer.During an interview on 2/13/26 at 11:18 a.m., the DON indicated residents who required EBP had signage on their door. A gown and gloves must be worn during any type of resident care. If a resident had a closed wound and a PICC or another medical device, EBP would still be required.During an interview on 2/13/26 at 11:29 a.m., the Infection Preventionist indicated a resident required EBP when they had an open wound that required treatment or if they had medical devices. If staff were providing care for the resident, a gown and gloves must be worn.A current facility policy, titled, Enhanced Barrier Precautions, revised 2/5/25, indicated the following: .Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.a. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO [multi-drug resistant organism] that is not currently targeted by CDC but may be considered epidemiologically important.4. High-contact resident care activities include:.Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters, h. Wound care: any skin opening requiring a dressing.9. Additional epidemiologically important MDROs may include, but are not limited to: a. Methicillin-resistant Staphylococcus aureus (MRSA).c. Vancomycin-resistant Enterococci (VRE).10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.3.1-18(a)