STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155546	A. BUILDING 00 B. WING	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHEL POINTE HEALTH AND REHAB	3400 W COMMUNITY DR MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00435685, IN00435804, IN00435137, and IN00433981. Complaint IN00435685- No deficiencies related to the allegations were cited. Complaint IN00435804- No deficiencies related to the allegations were cited. Complaint IN00435137- No deficiencies related to the allegations were cited. Complaint IN00433981- Defeciencies related to the allegation were cited at F686. Survey dates: June 3, 4, 5, 6, and 7, 2024 Facility number: 000565 Provider number: 155546 AIM number: 100267630 Census Bed Type: SNF/NF: 96 SNF: 7 Total: 103 Census Payor Type: Medicare: 7 Medicaid: 52 Other: 44 Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Selina Holloway	HFA	06/24/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Quality review completed June 10, 2024.			
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure an apical pulse was obtained prior to the administration of digoxin for 1 of 8 residents observed during medication administration (Resident 58). Finding includes: During a medication administration observation, on 6/6/24 at 8:33 a.m., RN 3 checked Resident 58's medications with the medication administration record. She opened plastic packages containing the medications. This included aspirin 81 mg, a multivitamin, cetirizine 5 mg (allergy symptoms), digoxin 125 mcg (micrograms) (heart failure/irregular heart rhythm), Eliquis 2.5 mg (blood thinner), Floranex (probiotic), furosemide 20 mg (diuretic), hydrochlorothiazide (blood pressure/diuretic), losartan 25 mg (blood pressure), metoprolol succinate extended release 100 mg (blood pressure/heart failure), potassium extended release 10 mEq (milliequivalents), and vitamin D3 50 mcg, and placed them in a medication cup. She took the medication cup and a Trelegy Ellipta inhaler into Resident 58's room. She instructed Resident 58 to take a puff from the inhaler, take a sip of water, and swish, then spit the water into a cup. She gave the medication cup containing the pills to the resident, and the resident swallowed the medications. She did not	F 0658	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 58 was not harmed. Her pulse was checked. Her physician was notified. Orders were obtained for hold and call parameters. 2. A facility-wide audit was completed and 2 additional residents were identified as taking digoxin. The physician was notified and hold/call orders were obtained. Additionally, EMAR templates were changed to include both pulse checks automatically with all digoxin orders. 3. The Medication Administration policy was reviewed and no changes were indicated. Licensed staff and QMA's will be re-educated on the policy. The DON or her designee will review orders twice weekly for 6 weeks and until 100% compliance is achieved to ensure parameters are not missed, then twice monthly for 6 months and until 100% compliance is maintained.	06/28/2024

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	obtain the resident's pulse prior to the medication administration. Resident 58's record was reviewed on 6/6/24 at 2:34 p.m. Diagnoses included atrial fibrillation (irregular heartbeat). Her physician's orders included digoxin 125 mcg daily (3/30/21). The order lacked parameters for when to hold the medication or notify the physician. The Pulse Summary indicated the pulse was 62 on 6/2/24, 85 on 5/17/24, and 70 on 5/2/24. The record lacked additional pulses from 5/2/24 through 6/6/24 . During an interview, on 6/6/24 at 4:39 p.m., RN 3 indicated she had not obtained a pulse on the resident. She had used the pulse obtained by the night shift nurse obtained earlier that day. During an interview, on 6/6/24 at 4:46 p.m., LPN 4 indicated when a resident received digoxin, the pulse and blood pressure were checked. Generally, if the resident's pulse was below 60, the digoxin was held, the physician was notified and would check if the physician wanted to add parameters for the pulse. During an interview, on 6/6/24 at 4:49 p.m., LPN 5 indicated a resident who received digoxin would have digoxin levels checked and should have orders to check pulse and blood pressure routinely with administration. During an interview, on 6/6/24 at 4:57 p.m., RN 3 indicated the resident's pulse had been taken at 5:30 a.m. by the night shift nurse, and she had forgotten to document it in the resident's record.		4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action will be adjusted accordingly.	

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	She had the pulse written down on the Report Sheet. During an interview, on 6/7/24 at 1:05 p.m., the DON indicated physician's orders should be followed when giving medications. She would expect a pulse to be obtained prior to the administration of digoxin. Davis's Drug Guide website, https://www.drugguide.com/ddo/view/Davis-Drug-Guide/51218/all/digoxin#9, accessed on 6/06/24 at 4:01 p.m., indicated the following: " ...Monitor apical pulse for 1 full min before administering. Hold dose and notify health care professional if pulse rate is <60 bpm [beats per minute] in an adult, <70 bpm in a child, or <90 bpm in an infant. Notify health care professional promptly of any significant changes in rate, rhythm, or quality of pulse ...." A current facility policy, dated 2/1/18, provided by the Administrator on 6/7/24 at 9:03 a.m., titled "Medication Administration," indicated the following: " ...perform any pre-administration checks/parameters (i.e. pulse, blood pressure) prior to prepping medication(s) for ingestion ...." 3.1-48(a)(3)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop			

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	pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide monitoring of a pressure injury and to develop and implement interventions to promote the healing of a pressure injury for 1 of 3 residents reviewed for pressure injuries (Resident C). Findings include: During an observation, on 6/4/24 at 10:12 a.m., Resident C was lying on her right side on a low air loss mattress at a 30-degree angle. During an observation, on 6/5/24 at 12:29 p.m., the resident was sitting up in bed. During an observation, on 6/6/24 at 3:34 p.m., the resident was lying on her right side on a low air loss mattress. Resident C's clinical record was reviewed on 6/4/24 at 3:57 p.m. Her diagnoses included age-related debility, disorientation, cauda equina syndrome, unspecified dementia unspecified severity with psychotic disturbance, chronic right heart failure, chronic kidney disease, and unspecified severe protein-calorie malnutrition. Current physician's orders included Allevyn adhesive external pad (wound dressing) - apply to left buttock topically every day shift (4/19/24) and Dakins (1/4 strength) external solution - apply to	F 0686	The facility will ensure this requirement is met through the following corrective measures: 1. Resident C's wound continues to improve with treatment. 2. All residents at risk for the development of pressure areas are at risk. No new areas related to pain complaints have been identified. Wound consultant NP documentation was obtained, along with facility NP documentation, and reviewed to ensure documentation is appropriate and has been addressed accordingly. 3. The Pressure Injury Prevention and Management policy was reviewed and no changes were indicated. Licensed nursing staff will be educated on this policy. The DON or her designee will review progress notes and consultant NP/MD notes five times weekly and as received for 6 weeks to ensure timely assessment and/or intervention, as indicated, and until 100% compliance is achieved, then twice weekly for 6 months and until 100% compliance is maintained.	06/28/2024

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	left buttock topically every day shift. Cleanse the wound to the left buttock with Dakin's solution, pack wound with Dakin's soaked kerlix, then cover with Allevyn. Change daily and as needed for soilage or displacement (4/20/24). A quarterly Minimum Data Set (MDS) assessment on 1/18/24 indicated the resident was moderately cognitively impaired. She required substantial/maximal assistance of staff for toileting, lower body dressing, personal hygiene, rolling to right and left, moving from sitting to lying position, moving from sitting to standing position, transfers to and from the toilet, and transfers to and from the tub/shower. The resident was frequently incontinent of bowel and bladder. She was at risk for a pressure injury. A care plan focus, initiated 12/22/23, revised 5/1/24, indicated the resident was at risk for developing more pressure ulcers related to requiring assist with bed mobility and incontinence. Interventions, initiated on 12/22/23, included the following: I will rest on a pressure redistribution surface, I will turn and reposition frequently and ask for assistance as needed, and You will give incontinence care to me and apply barrier cream as needed. The care plan lacked interventions initiated after 12/22/23. A care plan focus, initiated 4/28/24, indicated the resident had an unstageable pressure ulcer related to skin failure. Interventions, initiated 4/28/24, included the following: I will rest on a pressure reducing mattress, I will receive my treatment as ordered, I will report and you will observe for signs/symptoms of infection such as increased redness, warmth, induration at or near wound edges, foul odorous drainage.		4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	A Physiatry Progress Note, dated 1/22/24 at 3:04 p.m., indicated the resident was having some sacral discomfort from her "pressure sore". The resident's clinical record lacked a wound assessment or a treatment of the resident's pressure injury between 1/22/24 and 1/30/24. The Wound Consultant Note, dated 1/30/24, indicated the resident was being seen for assessment of a pressure injury located on the coccyx. Previous wound treatments included barrier products. The wound was staged as a stage 3 (Full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss.) pressure injury to the left gluteal with a length of 0.6 cm by a width of 0.8 cm with less than a 0.1 cm depth. The wound bed was 50% granular (red, bumpy tissue that is healing) and 50 % slough (nonviable tissue). The plan was a return visit in one week. Current treatment included a hydrocolloid dressing. On the same assessment, a stage 1 (Observable, pressure-related alteration of intact skin with non-blanchable redness of a localized area usually over a bony prominence) pressure injury was located on the coccyx with measurements of 0.5 cm long by 0.5 cm wide by less than 0.1 cm deep. The tissue was epithelial (Appears pink or pearly white and wrinkles when touched. Occurs in the final stage of healing when the wound is covered by healthy epithelium.). A Skin & Wound assessment, dated 2/1/24, indicated the resident had a new stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising.) pressure injury to the sacrum with a length of 1.4 cm, a width of 1.1 cm, and a			

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	depth of 0.1 cm. The wound bed was 70% filled with eschar and 30% filled with slough. The wound had a moderate amount of serous (clear to yellow fluid) drainage. The resident had continuous pain to the area. A Nurse Note, dated 2/1/24 at 5:06 p.m., indicated the resident had received a new physician order for Medihoney - apply to the coccyx every day shift for wound healing. A Skin & Wound assessment, dated 2/8/24 at 11:42 a.m., indicated the resident had a stage 2 pressure injury to the sacrum that measured 0.9 cm long by 0.6 cm wide by 0.1 cm deep. The wound bed was 50% filled by granulation and 50% filled by slough. The resident's clinical record lacked a wound assessment between 2/8/24 and 2/16/24. A Skin & Wound assessment, dated 2/16/24 at 11:45 a.m., indicated the resident had a stage 2 pressure injury to the sacrum that measured 2.2 cm long by 1.7 cm wide by 0.1 cm deep. The wound bed was 50% filled by granulation and 50% filled by slough. The resident's clinical record lacked a wound assessment between 2/16/24 and 2/25/24. A Skin & Wound assessment, dated 2/25/24 at 10:06 a.m., indicated the resident had a stage 2 pressure injury to the sacrum that measured 1.4 cm long by 2.0 cm wide by 0.1 cm deep. The wound bed was 10% filled by granulation, 70% filled by slough, and 20% filled by eschar. A Skin & Wound assessment, dated 3/28/24 at 10:01 a.m., indicated the resident had an			

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	unstageable (Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.) pressure injury to the sacrum that measured 3.9 cm long by 3.9 cm wide and depth not applicable. The wound bed was 10% filled by granulation, 20% filled by slough, and 70 % filled by eschar. A Nurse Note, dated 4/12/24 at 5:11 p.m., indicated the resident returned from the hospital on hospice care and had an unstageable pressure injury to the sacrum. A Skin & Wound assessment, dated 4/25/24 at 11:16 a.m., indicated the resident had an unstageable pressure injury to the sacrum that measured 2.4 cm long by 4.0 cm wide by 1.4 cm deep. The wound bed was 90% filled by granulation and 10% filled by slough. A Skin & Wound assessment, dated 5/30/23 at 11:32 a.m., indicated the resident had a stage 3 pressure injury to the sacrum that measured 2.0 cm long by 1.8 cm wide and depth not applicable. The wound bed was 100% filled by granulation. During a wound treatment observation, on 6/6/24 at 10:53 a.m., the Wound Nurse while wearing gown and gloves removed the wound dressing and packing from the resident's sacral area on the left buttock. The wound was cleansed, packed, and a new dressing was applied. The wound bed was beefy red. The wound length was the diameter of a quarter, the width of the diameter of a nickel, and the depth of the diameter of a dime. During an interview, on 6/6/24 at 3:41 p.m., the Wound Nurse indicated the first assessment she			

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	did on the resident's sacral pressure injury was performed on 2/1/24. She was unaware of the Physician Assistant note completed on 1/22/24 indicated the resident had a "pressure sore" that caused her sacral discomfort. During an interview, on 6/7/24 at 10:57 a.m., CNA 7 indicated anytime she changed someone she looked for pressure areas and reported them to the nurse immediately. She checked the interventions on the computer for the residents. For Resident C she made sure she was turned every two hours. During an interview, on 6/7/24 at 11:11 a.m., the DON indicated she was unable to locate an assessment done on the "pressure sore" indicated by the Physiatry Physician Assistant (PA) note on 1/22/24. She was unaware the 1/30/24 Wound Consultant Note indicated the resident had a wound on her left gluteal. The CNAs were supposed to mark on the shower sheets when the residents had a new area. The shower sheets for the time period did not show a new area. She deferred to the Wound Nurse about pressure injury staging and characteristics. During an interview, on 6/7/24 at 11:41 a.m., the Wound Nurse indicated the on admission the resident had a previously healed stage 1 pressure injury but was uncertain what the Wound Consultant was referring to in her note. She was uncertain why the facility had not received additional notes from the Wound Consultant. She was going to request to see if there were additional notes the facility had not received. She had left a message with the Wound NP. During an interview, on 6/7/24 at 12:31 p.m., the PA indicated in her documentation when she wrote "pressure sore" the area would not have			

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	been open, or she would have written ulcer. If she wrote sore, then she would have been there during care and saw the resident had a red, tender area. During an interview, on 6/7/24 at 1:16 p.m., the Wound Nurse indicated she had a picture of the wound on 2/1/24. The wound had dark tissue on wound base and a yellow area from 2 to 6 using a clock. She had documented the area was eschar but thought now it was dried blood when she looked at it. If the wound had slough or eschar would be a stage 3 wound. She had mistakenly called the wound bed eschar and slough. The wound picture did not clearly identify the wound bed as dried blood or the yellow area as denuded (loss of epidermis) skin. A current facility policy, dated 11/29/23, provided by the DON on 6/7/24 at 12:38 p.m., titled "Pressure Injury Prevention and Management," indicated the following: "Policy: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection, and the development of additional pressure ulcers/injuries ...4. Interventions for Prevention and to Promote Healing ... d. Evidence based treatment in accordance with current standards of practice will be provided for all residents who have a pressure injury present ...ii. Treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate (if present), presence of pain, signs of infection, wound bed, wound edge, and surrounding tissue characteristics ... 5. Monitoring a. The Wound Nurse, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards			

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	healing, and compliance at least weekly, and document a summary of findings in the medical record ...." This citation is related to conplaint IN00433981. 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure an indwelling catheter and tubing was positioned properly to avoid contamination for 1 of 1 residents reviewed with urinary catheter (Resident C). Finding includes: During an observation, on 6/4/24 at 10:12 a.m., Resident C was lying on her right side. Her catheter drained dark yellow urine with a large amount of sediment in the tubing. During an observation, on 6/5/24 at 10:10 a.m., the resident was lying on her right side in bed, with her covered catheter bag hanging off the bed frame and touching the floor mat along with the catheter tubing towards the door. During an observation, on 6/5/24 at 10:43 a.m., LPN 9 stopped, looked into the resident room then continued to walk to the nurse's station. During an observation, on 6/5/24 at 11:11 a.m., the resident's covered catheter bag and tubing remained laying on the fall mat on the floor towards the door. During an observation, on 6/5/24 at 11:13 a.m., CNA 10 entered the resident's room after applying a gown and gloves. During an observation, on 6/5/23 at 11:17 a.m., CNA 10 exited the resident's room.	F 0690	The facility will ensure this requirement is met through the following corrective measures: !. Resident C was not harmed. Low profile catheter bags and covers were obtained and will be utilized. 2. All residents with catheters were reviewed to ensure the catheters would not touch the floor when positioned properly. No additional residents were identified as being in a bed in the low position. Additional low profile catheter bags will be kept on site in the event one is needed. 3. The catheter care policy was reviewed and no changes were indicated. Nursing staff will be re-educated on this policy. The DON or her designee will make rounds 3 times weekly for 6 weeks and until 100% compliance is achieved to ensure catheter bags and tubing are not touching the floor, then weekly for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the monthly QAPI meetings and the plan of action adjusted accordingly.	06/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155546	A. BUILDING 00 B. WING	06/07/2024

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	During an observation, on 6/5/23 at 11:23 a.m., the resident was lying on her left side. The covered catheter bag and catheter tubing laid on the fall mat on the floor towards the door. During an observation, on 6/5/24 at 12:10 p.m., LPN 9 checked on Resident C and asked if she would like something else to eat. The resident indicated she would eat some soup. LPN 9 walked down the hall toward the kitchen. The covered catheter bag and catheter tubing laid on the fall mat on the floor towards the door. During an observation, on 6/5/24 at 12:29 p.m., the resident was sitting up in bed, she had eaten her soup. The covered catheter bag and tubing laid on the fall mat on the floor towards the door. Resident's C clinical record was reviewed on 6/4/24 at 3:57 p.m. Diagnoses included personal history of urinary tract infections, chronic kidney disease, stage 3, age-related debility, and unspecified dementia. Current physician orders included 16 French foley catheter with 10 mL bulb for neurogenic bladder initiated 4/19/24, Catheter care every shift and as needed every shift for preventative and as needed. A significant change Minimum Data Set (MDS) assessment on 4/18/24 indicated the resident was severely cognitively impaired. She was dependent on staff for toileting, showering, lower body dressing, personal hygiene, moving from sitting to lying position, moving from lying to sitting position, and transfers. She required substantial/maximal assistance rolling left and right.			

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	A care plan, initiated on 4/28/24, indicated the resident had an indwelling catheter related to the pressure injury on her sacrum and urinary retention. A Nurse Note, dated 5/15/24 at 7:05 p.m., indicated the catheter was flowing with dark yellow urine. During an interview, on 6/7/24 at 10:58 a.m., CNA 7 indicated for catheter care she made sure the catheter bag was in a privacy bag, the tubing was not in a knot, and the catheter bag and tubing were not laying on the floor. During an interview, on 6/7/24 at 11:05 a.m., LPN 5 indicated as she walked by residents' rooms who had catheters, she checked the catheter bags were in privacy bags, the tubing was not kinked and patent. She also checked to make sure the catheter bag and tubing were below the bladder and not on the floor. During an interview, on 6/7/24 at 11:45 a.m., the DON indicated the catheter bags and tubing should not be resting on the floor and expected staff to monitor that. A current facility policy, dated 11/27/23, provided by the DON on 6/7/24 at 12:38 p.m., titled "Catheter Care," indicated the following: " ...It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care ...."			