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	12/20/2022

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 the Investigation of Complaints IN00394932, IN00394882, IN00395530 and IN00395785. Complaint IN00394882 - Unsubstantiated due to lack of evidence. Complaint IN00394932 - Substantiated. Federal/State deficiencies related to the allegations are cited at F658. Complaint IN00395530 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00395785 - Substantiated. No deficiencies related to the allegations were cited. Survey dates: December 19 and 20, 2022 Facility number: 000565 Provider number: 155546 AIM number: 100267630 Census Bed Type: SNF/NF: 90 SNF: 8 Total: 98 Census Payor Type: Medicare: 9 Medicaid: 55 Other: 34 Total: 98 This deficiency reflects 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
Derek Gibson	Administrator	01/03/2023

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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BETHEL POINTE HEALTH AND REHAB	3400 W COMMUNITY DR MUNCIE, IN 47304

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	Quality review completed December 21, 2022.			
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 medication was administered under direct observation, for a resident who did not self-administer, during a random observation (Resident K). Findings include: During an interview with Resident K, on 12/19/22 at 9:58 a.m., a medication cup containing pills was observed on her overbed table. She indicated she could not take her medication in bed because of reflux issues. She needed to talk to QMA 5 because she had provided the resident's medicine earlier in the morning and forgot the blue pill she had been taking the last couple of days. During an interview with LPN 7, on 12/19/22 at 10:03 a.m., she indicated QMA 5 had worked in the morning and went to find her. After speaking with QMA 9, she indicated to her QMA 5 had left at 8:00 a.m. LPN 7 looked in the medication cart and found the resident's "blue pill", bupropion (antidepressant), had not been administered for the day's dose. The resident's physician orders indicated Resident K's medication was to be administered by the facility. Resident K's clinical record was reviewed on 12/19/22 at 10:30 a.m.	F 0658	The facility will ensure this requirement is met through the following corrective measures: 1. Resident K was not harmed. She was administered and consumed her medications. 2. All residents who do not have orders to self-administer have the potential to be affected. See below for corrective measures. 3. The policy on General Medication Administration Guidelines were reviewed and no changes were indicated. Licensed staff and QMA's will be educated on this policy. The DON or her designee will observe 5 random medication passes weekly for 6 weeks and until 100% compliance is achieved to ensure medications are not left at the bedside and signed off appropriately on the eMAR. Then, the observations will be completed 4 times monthly for 5 months and until 100% compliance is maintained. 4. The findings of these observations will be presented during the facility's monthly QAPI meetings and the plan of action	01/10/2023

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	Her medication administration record indicated her medications had not been signed off by QMA 5 for the morning of 12/19/22. A quarterly MDS (Minimum Data Set), dated 11/30/22, indicated that she was cognitively intact. A review of Resident K's medication administration record, on 12/20/22 at 9:00 a.m., indicated her medications had been signed off as adminsitrered by QMA 9. During an interview with the ADON, on 12/20/22 at 9:13 a.m., she indicated Resident K's medications for the morning of 12/19/22 were signed off by QMA 9 and it was probably because she was in a panic mode and thought they needed signed off, so she did. A current facility policy, titled "Medication Administration," provided by the Administrator on 12/19/22 at 12:03 a.m., indicated the following: "...Procedure: 1) Preparation/Administration...x. Licensed nurse/authorized personnel MUST stay with resident to ensure medication (s) are completely ingested. 2) Documentation a. Documentation is completed on the MAR/eMAR immediately after medication(s) ingested by resident and is completed by the licensed nurse/authorized personnel who administered the medication (s)...." This Federal tag relates to complaint IN00394932. 3.1-35(g)(1)		adjusted accordingly.	