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

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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 01/22/2026
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide/offer showers according to the resident's preferences to maintain proper hygiene for 1 of 3 residents reviewed for activities of daily living. (Resident B)Finding includes: Resident B's closed clinical record was reviewed on 1/22/26 at 11:16 a.m. The resident discharged from the facility on 1/7/26. Diagnoses included major depressive disorder, syncope and collapse, general muscle weakness, difficulty in walking, other abnormalities of gait and mobility, and a history of falling.An 11/11/25, admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. He used a walker and wheelchair for mobility. The resident required substantial staff assistance for lower body dressing, footwear donning, bathing, and shower transfers. He was dependent on staff assistance for toileting hygiene. Resident B required partial staff assistance to stand and transfer to the toilet. He occasionally had incontinence of urine. The resident had bowel incontinence. The resident had unhealed pressure ulcers, a surgical wound, and moisture acquired skin damage (MASD). Skin interventions included a pressure reducing device for the chair, nutrition/hydration, pressure injury care, surgical wound care, application of non-surgical dressings, and applications of ointments/medications. Resident B's care plans included the following:An 11/8/25 problem of required assistance with activities of daily living. Interventions included the following: I require assistance from one staff for a.m. and p.m. care (11/8/25), I require assistance of one staff for getting dressed (11/8/25), I require assistance of one staff for bathing (11/8/25).An 11/10/25 specific choices care plan. Interventions included the resident's preference to have his showers on Tuesday and Friday day shifts (11/10/25). The care plan lacked any indication that the resident was not compliant with bathing.An 11/11/25 problem of impaired skin integrity impairment related to MASD (moisture associated dermatitis) to the buttocks related to incontinence and excessive moisture. Interventions included resident education and reminders as needed regarding skin on skin, good hygiene, and changing of clothing and undergarments daily (11/11/25).A progress note, dated 12/15/25, indicated the resident attended an appointment in the community on this date.Review of the facility's clinical schedules indicated CNA 3 was on duty for the resident on 12/15/25, when the resident went out to the community for his appointment.Review of a grievance form, filed 12/18/25, indicated Resident B's representative reported concerns of the resident having the same clothes on for two days. The resident was sent to an appointment in the community, messy with feces, and without a brief.The facility investigation in response to the grievance indicated interviews with the nurse and CNA 3. CNA 3 went in prior to the resident's appointment to change clothes, clean up, and put a new brief on the resident. Resident B declined needing changed because he was in a clean brief and told CNA 3 his clothes were fine as he just wore them for one day prior. The investigation conclusion indicated an explanation was given to the representative that the resident was able to make his own decisions. Corrective action if necessary: Staff will notify the representative if the resident refuses to (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change briefs or clothes again.Date resolved: 12/18/25. Resident/representative response to resolution: The resident and representative agreed with the resolution with no further concerns.Review of Resident B's bathing documentation indicated the following information:On Tuesday, 11/25/25, the resident refused, On Friday, 11/28/25, the resident received a bed bath and shampoo,On Tuesday, 12/2/25, the resident refused, On Friday, 12/5/25, the resident refused,On Tuesday, 12/9/25, the resident refused, On Friday, 12/12/25, the resident received a shower and shampoo,On Tuesday, 12/16/25, the record lacked any bathing information,On Friday, 12/19/25, the record lacked any bathing information,On Tuesday, 12/23/25, the resident refused,On Friday, 12/26/25, the record lacked any bathing information,On Tuesday, 12/30/25, the record lacked any bathing information,On Friday, 1/2/26, the record lacked any bathing information, [NAME] Tuesday, 1/6/26, the record lacked any bathing information.The clinical record lacked any additional attempts, education, nurse notification, or family notification to engage the resident in bathing on the dates recorded as refusals. During an interview on 1/22/26 at 1:43 p.m., CNA 3 indicated he was familiar with Resident B. The resident was pleasant and cooperative with care assistance. The resident was compliant with toileting and always willing to get cleaned up and dressed every day. CNA 3 was uncertain if the resident refused showers. On 1/22/26 at 3:32 p.m., the Administrator indicated the facility reached out to the resident representative regarding feedback left on the resident portal and initiated a grievance. Staff indicated the resident had refused care prior to the appointment. The resident denied refusal of care. After the solution was provided to the representative, she was unaware of any further hygiene concerns. On 1/22/26 at 4:15 p.m., the DON indicated the facility was no longer required to chart the morning and evening care and the assistance the resident received for dressing each day. These items were a normal standard of care. She did not have any information to show the resident had been assisted with dressing each day.On 1/22/26 at 4:48 p.m., QMA 4 indicated residents were required to provide/offer bathing according to the resident's preference each week. When a resident refused bathing, the staff were required to reapproach the resident three times to encourage bathing. After three refusals, then the refusal was reported to the nurse and documented in the clinical record and on the shower sheets. The shower sheet refusals were signed by the nurse notified and the CNA who offered the showers. It was not acceptable practice to leave the residents' bathing or refusals uncharted.On 1/22/26 at 4:54 p.m., QMA 5 indicated she was familiar with Resident B. The resident was cooperative with care. He required assistance from one staff member for toileting. None of the CNAs had reported any concerns to her about shower refusals nor noncompliance with incontinence care for Resident B. The resident did not bring any concerns to her attention. On 1/22/26 at 5:01 p.m., the DON indicated she was unable to provide any further information regarding the resident's bathing. The clinical record lacked any notification for shower refusals to the nurse or the resident's family. Resident B's bathing information was left blank on 12/16/25, 12/19/25, 12/26/25,12/30/25, 1/2/26 and 1/6/26. One could not identify the resident was offered bathing because it was not in the clinical record. Residents have the right to be provided/offered showers according to their preference.A current facility policy, dated 11/29/23, titled Resident Showers, provided by the DON on 1/22/26 at 5:05 p.m., indicated the following: Policy: It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice.This citation relates to Intake 2697020.3.1-38(a)(2)3.1-38(b)(2)3.1-38(f)