STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Health & Rehabilitation, The	540 Belmont Drive Columbus, IN 47201

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(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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38769 Based on record review and interview, the facility failed to follow physician's orders related to hold parameters for medications for 5 of 24 residents reviewed for Quality of Care. (Residents 76, 4, 65, 98, and 38) Finding include: 1. The clinical record for Resident 76 was reviewed on 09/23/24 at 9:21 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/28/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, heart failure, and hypertension. An open-ended physician's order, with a start date of 01/23/24, indicated the resident was to take Humalog (an insulin) 10 units before meals. The staff were to hold the Humalog if the blood sugar was less than 120. The August and September 2024 EMAR (Electronic Medication Administration Record) indicated the resident received the medication on the following dates and times when the blood sugar was less than 120: - 08/20/24 at 7:30 A.M., when the blood sugar was 101, - 09/01/24 at 7:30 A.M., when the blood sugar was 105, - 09/07/24 at 7:30 A.M., when the blood sugar was 100, and - 09/ 13/24 at 7:30 A.M., when the blood sugar was 101. 2. The clinical record for Resident 4 was reviewed on 09/24/24 at 1:37 P.M. An Annual MDS assessment, dated 07/11/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, hypertension, and atrial fibrillation. An open-ended physician's order, with a start date of 08/05/24, indicated the resident was to be given metoprolol 12.5 mg (milligrams) at bedtime for hypertension. The staff were to hold (not give) the medication if the residents pulse was less than 60 or the systolic blood pressure (top number) was less than 120. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The August and September 2024 EMAR indicated the resident received the medication when his systolic blood pressure was less than 120 on the following dates and times: - 08/30/24, when the blood pressure was 106/67, - 09/07/24, when the blood pressure was 112/69, - 09/08/24, when the blood pressure was 112/69, and - 09/14/24, when the blood pressure was 107/53. 33613 3a. The clinical record for Resident 98 was reviewed on 09/19/24 at 10:24 A.M. A Quarterly MDS assessment, dated 07/01/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, a stroke, hypertension, diabetes, heart failure, Parkinson's disease, and depression. An open-ended physician's order, with a start date of 07/19/24, indicated the resident was to take aspart niacinamide (an insulin) 5 units before meals. The staff were to hold the insulin if the blood sugar was less than 120. The August and September 2024 EMAR indicated the resident received the medication on the following dates and times when the blood sugar was less than 120: - 08/06/24 at 11:00 A.M., when the blood sugar was 109, - 08/11/24 at 7:30 A.M., when the blood sugar was 112, - 08/12/24 at 4:00 P.M., when the blood sugar was 116, - 08/22/24 at 7:30 A.M., when the blood sugar was 112, - 09/12/24 at 4:00 P.M., when the blood sugar was 107, - 09/17/24 at 7:30 A.M., when the blood sugar was 97, - 09/17/24 at 4:00 P.M., when the blood sugar was 114, - 09/20/24 at 7:30 A.M., when the blood sugar was 117, - 09/21/24 at 7:30 A.M., when the blood sugar was 118, and - 09/23/24 at 7:30 A.M., when the blood sugar was 119. 3b. An open-ended physician's order, with a start date of 07/26/24, indicated the resident was to be given hydralazine 10 mg, three times a day for hypertension. The staff were to hold the medication if the resident's pulse was less than 60. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The August and September 2024 EMAR indicated the resident received the medication when his pulse was less than 60 on the following dates and times: - 08/01/24, when the pulse was 59 at 3:30 P.M., - 08/09/24, when the pulse was 57 at 3:30 P.M., - 08/14/24, when the pulse was 58 at 7:30 A.M., - 08/14/24, when the pulse was 58 at 3:30 P.M., - 08/15/24, when the pulse was 58 at 7:30 A.M., - 09/07/24, when the pulse was 57 at 3:30 P.M., and - 09/11/24, when the pulse was 59 at 11:30 P.M. 3c. An open-ended physician's order, with a start date of 03/26/24, indicated the resident was to be given metoprolol tartrate 50 mg, every 12 hours for hypertension. The staff were to hold the medication if the resident's pulse was less than 60. The August 2024 EMAR indicated the resident received the medication when his pulse was less than 60 on the following dates and times: - 08/14/24, when the pulse was 58 at 8:00 A.M., - 08/14/24, when the pulse was 58 at 8:00 P.M., and - 08/15/24, when the pulse was 58 at 8:00 A.M. During an interview on 09/24/24 at 9:05 A.M., RN 3 indicated for medications with hold parameters, staff should hold the medication and mark due to condition on the EMAR, then notify the physician. 34232 4. The clinical record for Resident 65 was reviewed on 09/19/24 at 11:04 A.M. A Significant Change MDS assessment, dated 07/09/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes, stroke, dementia, hypertension, and depression. The EMAR for August and September 2024 was provided by the ADON (Assistant Director of Nursing) on 09/24/24 at 3:52 P.M., and included the following current physician's order: - Midodrine 5 mg twice a day for a diagnosis of hypotension (low blood pressure), with a start date of 04/01/24. The medication was to be held (not given) if the systolic blood pressure was over 130. The medication was to be given on Day Shift, between 6:30 A.M. and 10:30 A.M., and on Evening Shift between 6:30 P.M. and 10:30 P.M. The record indicated the medication was administered when the resident's blood pressure was out of the prescribed range on the following dates and times: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 08/03/24, Evening Shift, the blood pressure was 138/76, - 08/08/24, Evening Shift, the blood pressure was 132/74, - 08/09/24, Day Shift, the blood pressure was 134/78, - 08/11/24, Evening Shift, the blood pressure was 142/82, - 08/12/24, Evening Shift, the blood pressure was 138/76, - 08/18/24, Evening Shift, the blood pressure was 134/86, - 08/19/24, Day Shift, the blood pressure was 132/88, - 08/19/24, Evening Shift, the blood pressure was 132/88, - 08/21/24, Evening Shift, the blood pressure was 132/78, - 08/25/24, Evening Shift, the blood pressure was 138/86, - 08/26/24, Day Shift, the blood pressure was 132/76, - 08/29/24, Day Shift, the blood pressure was 132/78, - 08/29/24, Evening Shift, the blood pressure was 132/78, - 09/01/24, Evening Shift, the blood pressure was 138/82, - 09/02/24, Day Shift, the blood pressure was 132/74, - 09/05/24, Evening Shift, the blood pressure was 150/88, - 09/06/24, Evening Shift, the blood pressure was 137/81, - 09/07/24, Day Shift, the blood pressure was 132/76, - 09/07/24, Evening Shift, the blood pressure was 139/56, and - 09/12/24, Day Shift, the blood pressure was 136/70. The current Care Plan for orthostatic hypotension was provided by the ADON on 09/24/24 at 3:29 P.M. The interventions included, but were not limited to, administer medications as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/23/24 at 3:21 P.M., RN 3 indicated for medications with hold parameters, staff should hold the medication and mark due to condition on the EMAR, then notify the physician. If there was a parameter, staff should take the vital sign right before giving the medication. On the EMAR there would be a notification if a resident required vital signs to be taken prior to medication administration. The special instructions on each medication will say which vital sign was required. The computer did not read the vital sign documented and tell you to hold the medication. The parameter would be stated on the physician's order. 38239 5. The clinical record for Resident 38 was reviewed on 09/23/24 at 10:48 A.M. A Quarterly MDS assessment, dated 08/29/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, coronary artery disease, and renal insufficiency An open-ended physician's order, with a start date of 02/16/24, indicated the resident was to be given losartan (a cardiac medication) 25 mg tablet. Give a half tablet (12.5 mg) once a day. The medication was to be held if the resident's systolic blood pressure was below 130. The June, July, August, and September 2024 EMAR indicated the resident received the medication when her systolic blood pressure was below 130 on the following dates: - 06/01/24, when the blood pressure was 129/75, - 06/03/24, when the blood pressure was 126/80, - 06/04/24, when the blood pressure was 128/74, - 06/08/24, when the blood pressure was 128/78, - 06/15/24, when the blood pressure was 122/80, - 06/16/24, when the blood pressure was 118/74, - 06/23/24, when the blood pressure was 118/80, - 06/25/24, when the blood pressure was 127/86, - 07/06/24, when the blood pressure was 128/70, - 07/13/24, when the blood pressure was 128/74, - 07/14/24, when the blood pressure was 128/74, - 07/27/24, when the blood pressure was 122/75, - 08/07/24, when the blood pressure was 122/80, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 08/17/24, when the blood pressure was 122/76, - 08/25/24, when the blood pressure was 123/74, - 09/12/24, when the blood pressure was 128/72, and - 09/15/24, when the blood pressure was 128/74. During an interview on 09/24/24 at 10:51 A.M., LPN 11 indicated if there were hold parameters for medications, she would assess the resident's vital signs as required and not administer the medication if the vitals were outside the ordered parameters. The current facility policy, titled PHYSICIAN ORDERS, dated 10/2014, was provided by the Regional Director on 09/24/24 at 3:00 P.M. The policy indicated, .Physician's orders are administered upon the clear, complete, and signed order of an individual lawfully authorized to prescribe .Facility nursing personnel will ensure clear, accurate, and complete physician's orders . 3.1-37(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 38239 Based on observation, interview, and record review, the facility failed to ensure pressure ulcers were accurately assessed, monitored, and treated for 1 of 8 residents reviewed for pressure ulcers. (Resident 40) Findings include: Resident 40 was observed in his room on 09/19/24 at 1:37 P.M. The resident was sitting up on the side of his bed with his overbed table in front of him. The resident was wearing thin, mid-calf length socks that covered his ankles. A pressure ulcer dressing was not visible. The resident indicated he had a wound on his left outer ankle and lowered his sock to expose the wound dressing. The dressing was clean, dry, and intact, and dated for that day. The resident's wound was observed with RN 9 on 09/20/24 at 11:50 A.M. The RN removed the resident's sock and dressing on his left outer ankle. The wound was nickel-sized, with a red wound bed and a small amount of slough (moist, non-viable tissue) present. There were no signs of infection. RN 9 indicated the resident had been laying in bed on his left side a lot when the wound was identified. They determined the wound was a pressure ulcer. The resident's clinical record was reviewed on 09/23/24 at 1:52 P.M. A Significant Change MDS (Minimum Data Set) assessment, dated 03/07/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, heart failure, peripheral vascular disease, and diabetes. The resident had no pressure ulcers but was at risk for pressure ulcers. An INITIAL PRESSURE ULCER ASSESSMENT, dated 04/16/24, indicated a Stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough) was identified on 04/16/24. The wound measured 0.5 cm (centimeters) X (by) 0.7 cm. There was purulent (containing pus), serous (clear/yellow), and bloody exudate (drainage/fluid). There was granulation (new) tissue in the wound bed. The assessment indicated the wound location was the right ankle, but that was crossed out and the left lateral ankle was listed as the location. The April and May 2024 EMAR (Electronic Medication Administration Record) included the following physician's orders: - An order with a start date of 04/17/24 and an end date of 05/02/24, indicated Wound Location: RIGHT LATERAL ANKLE. Monitor wound/peri wound for redness, swelling, change in drainage quantity/characteristics every shift. Notify medical provider of complications. The EMAR documentation indicated the wound was not monitored on the following date: - On 04/29/24 the evening shift nurse indicated they did not monitor the wound. They couldn't find the wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order with a start date of 04/17/24 and an end date of 05/02/24, indicated Wound Location: RIGHT LATERAL ANKLE. Once a day, cleanse open area with normal saline and pat dry. Apply skin protectant to peri wound. Apply calcium alginate to wound bed. Cover with border gauze dressing. The documentation indicated the treatment was not administered as ordered on the following dates: - On 04/25/24 the treatment was documented as not administered. A comment indicated na, - On 04/28/24 the treatment was documented as not administered. A comment indicated other, and - On 04/29/24 the treatment was documented as not administered. A comment indicated Could not find an open area. The ONGOING ASSESSMENT OF PRESSURE ULCER documentation indicated the following: - On 04/8/24, the wound measured 0.5 cm x 0.7 cm, with a depth of 0.1 cm. There was light serous exudate, and the wound bed was 100% granulation tissue. The wound was a Stage II pressure ulcer. - On 04/25/24, the wound measured 1.5 cm x 1.3 cm, with a depth of 0.1 cm. There was light serous exudate, and the wound bed was 100% granulation tissue. The wound was a Stage II pressure ulcer. - On 05/02/24, the wound measured 0.9 cm x 1.0 cm, with a depth of 0.2 cm. There was moderate serous exudate. The wound bed was 30% slough and 70% granulation tissue. The wound was now a Stage III pressure ulcer (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). The Wound Clinic Doctor was in to see the resident on 05/02/24. They debrided the wound (removed non-viable tissue) at that time and changed the wound treatment order to apply calcium alginate with silver to the wound once a day. A Nurses' Note, dated 05/02/24, indicated the facility was notified by the Wound Doctor that the order in the computer should be for the left ankle instead of the right ankle. The order was corrected. The current facility policy, titled PRESSURE ULCER PREVENTION, dated 10/2014, was provided by the Regional Director on 09/24/24 at 2:38 P.M. The policy indicated, .To prevent pressure ulcers and promote healing . The current facility policy, titled PHYSICIAN ORDERS, dated 10/2014, was provided by the Regional Director on 09/24/24 at 3:00 P.M. The policy indicated, .Facility nursing personnel will ensure clear, accurate, and complete physician's orders .Transcribe new order onto MAR or TAR, as indicated . 3.1-40(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34232 Based on observation, interview, and record review, the facility failed to provide a safe environment related to a resident's bed position for 1 of 6 residents reviewed for accidents. (Resident 15) Findings include: Incontinence care for Resident 15 was observed on 09/19/24 at 1:30 P.M., with providers CNA (Certified Nurse Aide) 6 and CNA 7. The CNAs washed their hands, prepared a basin of water, had clean linens at the bedside, and raised the resident's bed to the high position to perform the task. During the process, CNA 6 left the bedside and went into the resident's adjoining bathroom. After putting a bag in a trash can, CNA 7, left the bedside as well, walked around the edge of the bed and pulled privacy curtain, and was standing approximately three feet from the foot of the bed while the bed was in the high position. CNA 7 spoke to CNA 6, who was in the bathroom, for about a minute, then both CNAs returned to the bedside and continued with care. During an observation on 09/23/24 at 10:22 A.M., the resident was in their room in bed. The bed was in the high position, chest height. No staff were observed in the room or in the immediate area in the hallway. On 09/23/24 at 10:36 A.M., CNA 5 was observed entering the resident's room and lowering the bed. The CNA then walked across the hall into another resident's room, shutting the door. During an interview on 09/23/24 at 10:43 A.M., CNA 5 indicated Resident 15's bed probably should not have been left in the high position. During an interview on 09/23/24 at 3:19 P.M., RN 3 indicated the resident had a history of seizures. During an interview on 09/24/24 at 9:46 A.M., LPN (Licensed Practical Nurse) 4 indicated the resident was non-verbal, non-responsive, and unable to use their call light. The resident's hands were contracted. During an interview on 09/24/24 at 2:18 P.M., RN 3 indicated the resident was physically unable to adjust the height of their bed. Residents' beds should not be left in the high position when a resident was in the bed. Staff should not leave the bedside when a resident was in the bed and the bed was in the high position. The clinical record for Resident 15 was reviewed on 09/23/24 at 11:31 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/29/24, indicated the resident was rarely/never understood. The Resident's diagnoses included, but were not limited to, cancer, dementia, and seizure disorder. The resident's current Care Plans were provided by the Regional Director on 09/24/24 at 2:38 P.M., and included, but were not limited to, the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A Care Plan for Seizure Activity indicating the resident was at risk for injury, with interventions that included, but were not limited to, administering the medications of Lacosamide and Valporic Acid per the physician's orders, and - A Care Plan for Bed Mobility indicating the resident needed the assistance of two staff members due to cognitive loss, chronic pain syndrome, neoplasm of the brain, debility, and Alzheimer's disease. 3.1-45(a)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34232 Based on observation and interview, the facility failed to provide dining services in a sanitary manner related to clothing protectors and food service for 7 of 19 residents observed in the Main Dining Room, for 2 of 2 dining observations. (Residents 38, 106, 31, 137, 85, 86, and 109) Findings include: 1. Meal service was observed in the Main Dining Room on 09/17/24 at 12:03 P.M. AA (Activities Assistant) 2 held a clean stack of clothing protectors up against their chest touching their clothes, purse strap, and a coiled wrist band that was holding their keys. AA 2 assisted Resident 38, Resident 106, and Resident 31 with applying clothing protectors. At 12:06 P.M., AA 2 touched the front of their face mask, touched the remaining clothing protectors in their arms, then delivered a cup of fluid to Resident 31. AA 2 continued to hold the clothing protectors against their left chest, touching the coiled wrist band holding keys. AA 2 touched the front of their face mask again, took a cup from Resident 137, went to a drink station, touched the ice tongs, poured a drink from a common pitcher on counter into the cup, and returned the cup to Resident 137. AA 2 touched the front of their facemask, used hand sanitizer, and continued to hold clothing protectors to their chest. AA 2 put the clothing protectors down on an empty table and exited the Main Dining Room. 2. Meal service was observed in the Main Dining Room on 09/24/24 at 11:40 A.M. AA 2 used hand sanitizer, touched the front of their face mask, fixed a cup of cocoa at a common drink station, then served the cocoa to Resident 85. At 11:56 A.M., they fixed two cups of coffee and served them to Resident 86 and Resident 109. During an interview on 09/24/24 at 12:20 P.M., Administrator indicated staff members should not hold clean linens against their person and protective face masks should cover around the nose and mouth. The current LINEN, HANDLING policy, dated 12/2015, was provided by the Administrator on 09/24/24 at 12:28 P.M. The policy indicated, .The facility shall handle linen in a manner to prevent spread of infection . Linen will not be carried against the body . The current Glove Use & Meal Service policy, dated 05/2018, was provided by the Regional Director on 09/24/24 at 2:49 P.M. The policy indicated, .All objects (ie. watches) that could potentially contaminate food should be removed .If an employee .touches any area of their body - they MUST immediate [sic] wash their hands . 3.1-21(i)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38769 Based on observation, interview, and record review, the facility failed to follow infection control guidelines related to transmission-based precautions for COVID-19 and wound care for 1 of 3 residents reviewed for COVID-19 and 1 of 6 residents observed for wound care. (Residents 20 and 69) Findings include: 1. During an observation on 09/18/24 at 10:39 A.M., Physical Therapist 8 was sitting in a chair in Resident 20's room with a gown, gloves, and a surgical mask on. After a few minutes he disposed of his gown, gloves, and surgical mask at the door and exited. Upon exiting the room he retrieved an N95 mask, out of a three-drawer cart outside the room and donned the mask. He then walked down the hallway to another resident's room that was not on and transmission-based precautions. The cart outside Resident 20's room contained N95 masks, gowns, gloves, and face shields. A sign on the door indicated the room was a red zone, transmission-based precautions and contact isolation. PPE (Personnel Protective Equipment) was required to enter the room. An N95 mask, face shield or goggles, gown, and gloves. During an observation on 09/24/24 9:59 A.M., Resident 20 was in her room with her call light on. There was a sign on the door that indicated the resident was in a red zone. A three-drawer cart outside the resident's room contained N95 masks, gowns, gloves, and face shields. During an observation on 09/24/24 at 10:08 A.M., LPN (Licensed Practical Nurse) 10 entered the resident's room wearing only a surgical mask. The LPN had a brief conversation with the resident and turned off the resident's call light. During an interview on 09/24/24 at 10:10 A.M., LPN 10 indicated he believed the resident had COVID. When entering a COVID room, staff should wear an N95 mask and a gown. He should have worn an N95 mask and a blue gown when he had entered the resident's room. During an interview on 09/24/24 at 3:10 P.M., the ADON (Assistant Director of Nursing) indicated the resident was COVID positive on 09/14/24 and would be able to come out of isolation on 09/25/24. Staff were to wear an N95 face mask, face shield, a gown, and gloves when entering the residents room. The clinical record for the resident was reviewed on 09/23/24 at 10:18 A.M. An Admission MDS (Minimum Data Set) assessment, dated 08/19/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, pulmonary embolism, anemia, anxiety, depression, and respiratory failure. The LTC (Long Term Care) Respiratory Surveillance Line List indicated Resident 20 had a positive nasal swab on 09/14/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Health & Rehabilitation, The	540 Belmont Drive Columbus, IN 47201

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current facility policy titled, ISOLATION (TRANSMISSION BASED PRECAUTIONS) GUIDELINES dated 10/2015 was provided by the ADON on 09/24/24 at 3:29 P.M. The policy indicated, .Isolation procedures (i.e. , Transmission-Based Precautions) are designed to protect other residents, personnel and visitors from the spread of confirmed or suspected infection or contagious disease .The health care team and visitors should be instructed on the importance and necessity of maintaining precautions before entering the resident's room . 38239 2. On 09/20/24 at 11:34 A.M., RN 9 was observed as she provided wound care for Resident 69. The RN gathered supplies from her cart, entered the resident's room, and donned a gown and gloves. With her gloved hands she used the bed controller to raise the base of the bed, lower the head of the bed, and move the overbed table. She then closed the resident's door, adjusted the window blinds, and pulled the string to adjust the lighting above the bed. She opened a trash bag and placed it on the end of the bed and opened the wound dressing supplies. She sprayed cleanser on the gauze that was inside one package and labeled the dressing that was in the other package. The resident rolled to her side and the RN pulled the resident's blankets down and opened the resident's brief for access to the wound. There was no dressing on the wound. The wound was about 2 centimeters in diameter with a red wound bed, there were no signs of infection. The RN used a gauze pad and cleansed the wound. She then removed her gloves and washed her hands. During an interview on 09/20/24 at 2:35 P.M., RN 9 indicated she normally would not have had gloves on when she adjusted the resident's bed and blinds. She would normally do all of that stuff and then wash her hands and don gloves before cleansing the wound. The resident's clinical record was reviewed on 09/23/24 at 3:48 P.M. A Significant Change MDS assessment, dated 07/01/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, cancer, atrial fibrillation, and hypertension. The resident had an Unstageable pressure ulcer (obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough [non-viable tissue] or eschar [dead tissue] that was present on admission. The current facility policy, titled STEPS, INITIAL AND FINAL - PROVISION OF CARE, dated 10/2014, was provided by the ADON on 09/24/24 at 2:05 P.M. The policy indicated, .Gather supplies .close curtains, drapes, and doors .wash hands . The current facility policy, titled DRESSING - CLEAN TECHNIQUE, dated 10/2014, was provided by the ADON on 09/24/24 at 2:05 P.M. The policy indicated, .Perform necessary initial steps .remove gloves, wash hands, and put on a pair of clean gloves .cleanse wound . 3.1-18(b) 3.1-40(a)(2)