STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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 IN00411775. Complaint IN00411775 - No deficiencies related to the allegations are cited. Survey dates: July 6, 7, 10, 11, 12, and 13, 2023 Facility number: 000058 Provider number: 155133 AIM number: 100283340 Census Bed Type: SNF/NF: 101 Total: 101 Census Payor Type: Medicare: 6 Medicaid: 78 Other: 17 Total: 101 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 24, 2023.	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tyler Reed	Administrator	08/03/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review, interview, and observation, the facility failed to follow physician's orders related to medication administration parameters for cardiac medications for 1 of 7 residents reviewed for medications (Resident 12), complete neurological assessments after a fall for 1 of 4 residents reviewed for accidents (Resident 8) and follow manufacturer's guidelines related to insulin pen usage for 3 of 3 insulin medication administrations. (Residents 51, 15, and 3) Findings include: 1. Resident 12's clinical record was reviewed on 07/11/23 at 9:30 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 04/27/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure and hypertension. The resident's current MD orders included an open-ended order, with a start date of 01/27/23, for metoprolol succinate (a cardiac medication), 50 mg (milligrams) extended-release tablet once a day. The medication was to be held if the resident's pulse was less than 60 and their SBP (systolic blood pressure) was less than 90. During an interview on 07/11/23 at 10:24 A.M., LPN (Licensed Practical Nurse) 9 indicated the resident did have a medication that had hold parameters, she thought it was the resident's pulse that needed to be assessed prior to medication administration. Nursing staff were to obtain the vital sign required by the MD before	F 0684	F0684 Requires the facility follow physician's orders related to medication administration parameters for cardiac medications, complete neurological assessment, and follow manufacturer's guidelines related to insulin pen usage. 1. Resident #12 orders were reviewed and no changes made. Nursing staff was inserviced on following the parameter set by the physician when administering the cardiac medication. Resident #8 neurological assessment was completed and no concerns noted. Resident #3, #15 and #51 insulin was administered correctly per manufacturer’s guidelines. The nursing staff was inserviced immediately on the proper way to prime an insulin pen. 2. All residents have the potential to be affected. The nursing staff was inserviced on medication administration and ensuring parameters are being followed per the physician’s orders. The medication records were reviewed for last two weeks to ensure parameters are being followed. The nursing staff was inserviced on the neurological assessment and the timeliness needed to complete the assessment per policy. The last 30 days of	08/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	administering the medication. If the resident's pulse was outside of the administration parameters, she would not administer the medication and would notify the MD or Nurse Practitioner. The resident's May, June, and July 2023 EMAR (Electronic Medication Administration Record) indicated the metoprolol medication had been administered every day. The resident's pulse was assessed and documented on the EMAR. The EMAR lacked documentation of assessment of the resident's blood pressure before the medication was administered. During an interview on 07/13/23 at 10:05 A.M., LPN 9 indicated the resident's pulse was assessed before administering the medication, but the resident's blood pressure was not assessed. The MD order indicated the resident's pulse and blood pressure was to be assessed, but there was no space on the EMAR to document the blood pressure reading. The resident's blood pressure should have been assessed prior to administering the medication. The resident's Care Plans were reviewed on 07/12/23 at 1:52 P.M., and included a hypertension care plan, dated 01/30/23 with a revision date of 05/01/23. The interventions included, but were not limited to, administer medications as ordered, administer metoprolol as ordered. The current facility policy titled, "Medication Administration" with a revision date of 4/2017 and was provided by the Regional Director on 07/12/23 at 2:07 P.M. The policy indicated, "...To safely administer medications as per physicians' orders...Always take pulse and B/P as indicated if ordered prior to giving certain cardiac or		neurological assessments were reviewed to ensure neurological assessments are completed per policy. The nursing staff immediately was inserviced on the proper way to administer insulin per manufacturer's guidelines. Insulin orders and administration records were reviewed for the last 30 days to ensure insulin administered per policy. No concerns were noted. See below for corrective measures. 3. The medication administration, neurological assessment and the novolog package insert policy and procedure/ manufacturer's guidelines were reviewed with no changes made. (See attachment A, B and C) The staff was inserviced on the above procedures. 4. The DON or her designee will review the medication administration records to ensure that parameters are followed per the physician's order. The DON or her designee will review neurological assessments daily to ensure the assessment s are completed per policy. The DON or her designee will observe 3 administrations of insulin per an insulin pen daily to ensure the nursing staff is administering per the manufacturer's guidelines. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	antihypertensive drugs. Notify the physician if the vital signs are not within the acceptable range..." 2. Resident 8 was observed in his room in bed on 07/06/23 at 1:28 P.M. The resident indicated he had fallen a few times a while ago. He had some bumps and bruises from the falls and injured his shoulder. He hadn't had any recent falls. The resident's clinical record was reviewed on 07/12/23 at 1:39 P.M. A Significant Change MDS assessment, dated 05/10/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, dementia, anxiety, and diabetes. The resident required limited staff assistance with transfers and personal hygiene, extensive staff assistance with toileting, and supervision for walking. The resident had one fall without injury since the last assessment. A packet, titled "ACCIDENT & INCIDENT REPORT AND INVESTIGATION", was provided by the DON on 07/12/23 at 11:39 A.M. The documents indicated the resident experienced a fall on 05/21/23 at 4:30 A.M. The description indicated the resident was found sitting on the floor by the bathroom door in his room with his head against wall. The wall was noted to have blood on it. The resident was noted to have abrasion on the back of his head from rubbing his head against the wall. There were no other injuries noted. The resident was able to move his extremities normally except for the arm with the dislocated shoulder (fall records indicated the resident fell on 05/19/23 and dislocated his right shoulder). Neuro (Neurological) checks were initiated.		every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. If compliance is not obtained or maintained, the nursing staff will be re-educated one on one to ensure their knowledgeable about parameters, neurological assessments and priming an insulin pen. Increased monitoring will occur, medication records would be assessed twice a day to ensure parameters are followed and 5 observations of insulin pen administration per the manufacturer's guidelines if warranted as well. 5. The above corrective measures will be completed on or before August 7, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	The neurologic check flow sheet in the packet indicated the assessment frequency for the neuro checks. The resident was to be assessed as follows: - an initial check, - every 15 minutes x (times) 3, - every hour x 3, and - every 4 hours x 17, for a total of 72 hours of neuro checks. The resident's neurological check flowsheet lacked documentation of neuro checks after the first four assessments. During an interview on 07/11/23 at 10:55 A.M., LPN 9 indicated nursing staff were to initiate and complete neuro checks for any unwitnessed fall or fall with a head injury. During an interview on 07/12/23 at 11:21 A.M., the DON indicated it looked like the neurochecks for the fall on 05/21/23 at 4:30 A.M. were not complete. The current facility policy, titled "NEUROLOGICAL ASSESSMENT", with a most recent revision date of 03/19, was provided by the Regional Director on 07/13/23 at 11:45 A.M. The policy indicated, "...Neurological assessment, is to be completed in all cases of head injury to the resident (when suspected or known) at the following frequency: every 15 min x 1 hour; every hour x 3 hours; every 4 hours to complete 72 hours..." 3.a. During an observation on 07/07/23 at 11:45 A.M., LPN (Licensed Practical Nurse) 3 entered Resident 51's room to administer a sliding scale dose of insulin. The LPN primed two units on the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	Novolog insulin pen, with the cap on the needle she pointed the pen downward and dispensed the two units. LPN 3 then dialed the sliding scale dose of six units on the Novolog insulin pen and injected the insulin into the resident. b. During an observation on 07/10/23 at 11:50 A.M., LPN 4 entered Resident 15's room to administer a sliding scale dose of insulin. The LPN primed the Novolog insulin pen with two units, with the needle exposed she pointed the pen downward toward the trash can and dispensed the two units. LPN 4 then dialed the sliding scale dose of four units on the Novolog insulin pen and injected the insulin into the resident's left arm. c. During an observation on 07/11/23 at 11:45 A.M., RN 5 removed Resident 3's Humalog insulin pen from the medication cart, removed the pen cap, cleaned the tip of the pen, applied a new needle, removed the needle cap, primed the pen with two units of insulin, pointed the pen downward and dispensed the two units. RN 5 then dialed the sliding scale dose of three units and injected the Humalog insulin into the resident's left arm. During an interview on 07/11/23 at 11:55 A.M., RN 5 indicated she should have held the insulin pen upright when priming the pen with the two units. The current "Novolog Package Insert", with a revised date of 09/11/2015, was provided by the DON on 07/11/23 at 12:24 P.M. The insert indicated, "...Before each injection...Wipe the Rubber Seal with an alcohol swab. To avoid injecting air and to ensure proper dosing...Turn the dose selector to select 2 units. Hold your Pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the bottom all the way in...A drop of insulin should appear at the needle tip..." The current "Humalog Package Insert", with a revised date of November 2015, was provided by the DON on 07/11/23 at 12:24 P.M. The insert indicated, "...To prime your Pen, turn the Dose Knob to select 2 units, Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Continue holding your Pen with the Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window..." The current "Insulin Injections" policy, with a revised date of 07/2019, was provided by the DON (Director of Nursing) on 07/11/23 at 12:24 P.M. The policy lacked instructions for insulin pens. 3.1-37(a) 3.1-47(a)(1)			
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 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	promote healing, prevent infection and prevent new ulcers from developing. Based on interview, observation, and record review, the facility failed to identify pressure ulcers and follow interventions for pressure ulcers for 2 of 8 residents reviewed for pressure ulcers. (Residents 36 and 18) Findings include: 1. During an interview on 07/07/23 at 10:06 A.M., Resident 36 indicated she had little sores on her toes. During an observation on 07/10/23 at 1:24 P.M., Resident 36 was lying in her bed on her back with her feet curled up. During an observation on 07/11/23 at 10:08 A.M., Resident 36 was lying in her bed on her back with her feet curled up. During an observation on 07/12/23 at 9:59 A.M., Resident 36 was lying in her bed on her back with her feet curled up. During an interview on 07/12/23 at 10:04 A.M., LPN (Licensed Practical Nurse) 9 indicated the resident was pleasantly confused and required assistance of one staff member for activities of daily living. The resident had no sores at the time. During an observation and interview on 07/12/23 at 11:35 A.M., the ADON (Assistant Director of Nursing) had obtained permission from the resident to assess her feet. She propelled the resident to her room. The resident indicated her right toe was sore and her left foot was hurting also. The ADON applied gloves and removed the resident's right sock, and the following was	F 0686	F0686Requires the facility to identify pressure ulcers and follow interventions for pressure ulcer. 1. Resident #36 and Resident #18 wounds were measured and treatment orders were reviewed to ensure the orders are being followed. 2. All residents have the potential to be affected. A complete head to toe assessment was completed on all residents to ensure no skin issues were present without physician orders. No concerns were noted. See below for corrective measures. 3. The pressure ulcer policy and procedure/ manufacturer's guidelines were reviewed with no changes made. (See attachment E) The staff was inserviced on the above procedure. 4. The DON or her designee will complete a head to toe assessment on 10 residents daily to ensure all skin issues are noted and an appropriate treatment is ordered per the physician. These assessments will be in addition to the weekly assessment already yo be completed. The DON or her designee will also observe 10 residents to ensure the physician's orders for all pressure relieving boots are also followed as well. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then	08/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	observed: - The resident's right great toe had an area that measured 0.3 cm (centimeters) x (by) 0.3 cm. The area was pinkish in color. - The resident's right second toe had an area that covered the joints of the toe that measured 1 cm x 1.2 cm with a dark black center. The toe was bright red where it connected to the foot. The ADON indicated the wound had necrotic tissue. She removed the sock on the resident's left foot and the resident had an area to the inner heel that measured 2 cm x 2.2 cm. The wound had a necrotic center and white area around the outer side. The resident indicated the toe and heel were tender. The ADON indicated it was a deep tissue injury. She was unaware of the resident having any skin concerns. When the staff found a skin concern, they were to fill out a skin sheet and submit it to her. During an interview on 07/12/23 at 11:49 A.M., CNA (Certified Nurse Aide) 16 indicated she worked with Resident 36 frequently and she was unaware that the resident had any skin concerns until the ADON had just mentioned them to her. She had assisted the resident with getting dressed that morning. She always checked the residents' bottoms and under their breasts for skin concerns but had never thought to look at their feet. She would alert the nurse of new concerns. The clinical record for the resident was reviewed on 07/10/23 at 2:20 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 04/11/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, left femur fracture, anemia, Alzheimer's		weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. If compliance is not obtained or maintained, one on one re-education will occur to ensure nursing is completing their weekly head to toe assessment per policy and that physician orders are acknowledged and being followed for residents requiring pressure relieving boots. Increased monitoring will occur with the nurse consultant or her designee completing a weekly head to toe assessment on all residents weekly and observing pressure relieving boots are applied per the physician's order if warranted. 5. The above corrective measures will be completed on or before August 7, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	disease, anxiety, and depression. She was always incontinent of bowel and bladder and required total assistance of two or more staff with bed mobility, toileting, and transfers. She required extensive assist of one staff member for dressing and personal hygiene. The resident was at risk for development of pressure ulcer. The weekly skin assessment, nurse notes, and shower sheets lacked documentation the resident had any skin concerns. 2. During an observation and interview on 07/06/23 at 1:07 P.M., Resident 18 had soft foam boots sitting in her recliner and her feet were resting on the bed. She indicated the boots had been in her chair all day. During an observation on 07/11/23 at 2:21 P.M., the resident was lying in bed with her soft boots on. The ADON obtained permission to remove the boots and look at her heels. The boots were removed. The left heel skin was intact with no redness present. The right heel skin was intact with minimal redness. During an interview on 07/11/23 at 2:36 P.M., RN 14 indicated the resident wore soft boots for pressure ulcer prevention. During an interview on 07/12/23 at 11:30 A.M., the ADON indicated the resident had boggy heels that started in June. During an interview on 07/13/23 at 1:52 P.M., CNA 13 indicated the resident had soft boots she was supposed to wear while she was in bed. She started wearing the boots within the last couple of months.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	The clinical record for Resident 18 was reviewed on 07/10/23 at 2:04 P.M. A Quarterly MDS assessment, dated 05/30/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, heart failure, anemia, hypertension, Alzheimer's dementia, malnutrition, anxiety, depression, and respiratory failure. The resident was at risk for development of pressure ulcers. An "Initial Pressure Ulcer Assessment", dated 06/01/23, indicated the resident had a Stage 1 pressure ulcer to the left heel that measured 0.2 cm X 0.2 cm. The wound was intact with a pink wound bed. The area resolved on 07/04/23. An "Initial Pressure Ulcer Assessment", dated 06/01/23, indicated the resident had a Stage 1 pressure ulcer to the right heel that measured 0.2 cm X 0.2 cm. The wound was intact with a pink wound bed. The area was resolved on 07/04/23 with a new skin assessment completed for boggy bilateral heels. An "Initial Pressure Ulcer Assessment", dated 07/04/23, indicated the resident had boggy bilateral heels. The wound bed was pink blanching skin with pink wound edges. An open-ended physician's order, with a start date of 06/23/23, indicated to apply skin prep to the left heel at night and apply boot to foot. An open-ended physician's order, with a start date of 06/23/23, indicated to apply skin prep to the right heel at night and apply boot to foot. The July 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) lacked			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	documentation that the resident had refused to wear the boots on 07/06/23. The current facility policy, titled "Pressure Ulcers" dated 10/2014 was provided by the Regional Director on 07/13/23 at 11:55 A.M. The policy indicated, "...To assure that residents with pressure ulcers will receive necessary care and treatment to promote healing, prevent new ulcers from developing and prevent infection. The current facility policy, titled "Pressure Ulcer Prevention" dated 10/2014 was provided by the Regional Director on 07/13/23 at 11:55 A.M. The policy indicated, "...To prevent pressure ulcers and promote healing...heel boots...Inspect skin for redness/open areas during provision of daily care..." 3.1-40(a)(1)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure a resident with limited mobility received restorative nursing services for 1 of 3 residents reviewed for restorative services. (Resident 8) Findings include: Resident 8 was observed in his room in bed on 07/06/23 at 1:28 P.M. The resident indicated he had fallen a few times a while ago. He had some bumps and bruises from the falls and injured his shoulder. He hadn't had any recent falls. The resident's clinical record was reviewed on 07/12/23 at 1:39 P.M. A Significant Change MDS (Minimum Data Set) assessment, dated 05/10/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, dementia, anxiety, and diabetes. The resident required limited staff assistance with transfers and personal hygiene, extensive staff assistance with toileting, and supervision for walking. The resident had one fall without injury since the last assessment. The resident participated in speech, occupational, and physical therapy since the last assessment. During an interview on 07/10/23 at 11:18 A.M., the Therapy Manager indicated the resident had experienced some falls recently. The resident participated in physical therapy and was discharged from physical therapy with a restorative nursing program on 06/12/23. They had two restorative aides that tried to see the residents on the restorative program 2 to 5 times a week. The aides kept daily notes of the residents	F 0688	F0688 Requires the facility to ensure a resident with limited mobility received restorative nursing services 1. Resident #8 was placed on restorative nursing. 2. All residents have the potential to be affected. All residents were reviewed and residents requiring restorative nursing were on a program. 3. The restorative policy and procedure was reviewed with no changes made. (See attachment F) The staff was inserviced on the above procedure. 4. The DON or designee with review all therapy documentation once a resident is discontinued from therapy to ensure that all residents deemed appropriate for a restorative program is placed on an appropriate program. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. If compliance is not obtained or	08/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	they saw and what type of restorative services they provided in addition to a monthly tracking log for each resident. If a resident refused restorative services, the aides were to indicate the refusal on the monthly tracking log. The resident was on a restorative program for walking and to improve his strength. The Therapy Manager reviewed the monthly tracking logs for the resident for June and July 2023 and indicated the only documentation on the tracking log was that the resident refused to participate in the restorative program on 07/06/23. The Therapy Manager reviewed the Restorative Aide Daily Notes from 06/12/23 to 07/07/23 and indicated the only time the resident was listed on the daily notes was on 07/06/23 when he refused services. The resident's restorative program was provided by the Therapy Manager on 07/12/23 at 3:02 P.M. The program indicated the resident was enrolled in walking and strength programs, with a start date of 06/12/23. Specific program instructions included, but were not limited to the following: - Ambulate 100 feet with handheld support down the hallway, and - Perform bilateral lower extremity active range of motion exercises in a sitting or supine position, 10 repetitions x (times) 2 sets. The goal was to maintain the residents' mobility and the restorative program was signed by PT (Physical Therapist) 10. During an interview on 07/12/23 at 2:59 P.M., the Therapy Manager indicated she looked into what happened with the resident and it seemed each of the restorative aides thought the other one was working with the resident so neither of them put the resident on their list for restorative services		maintained, one on one re-education will occur with the DON to ensure she is thoroughly monitoring the documentation from therapy to ensure programs are being initiated. Increased monitoring would occur with the administrator also being responsible to monitor the documentation at this time to help ensure the residents receive restorative nursing when appropriate. 5. The above corrective measures will be completed on or before August 7, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	until 07/06/23. During an interview on 07/13/23 at 11:32 A.M., PT 10 indicated the resident was discharged from therapy (6/12/23) and a restorative program was initiated for the resident. The resident was expected to participate in a restorative program. The current facility policy, titled "RESTORATIVE NURSING SERVICES", dated 10/2014, was provided by the Regional Director on 07/13/23 at 12:06 P.M. The policy indicated, "...Residents identified as those who would benefit from restorative nursing services shall have the appropriate services initiated..." 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to investigate a fall for 1 of 4 residents reviewed for accidents. (Resident 90) Findings include: During an observation and interview on 07/10/23 at 10:35 A.M., Resident 90 was sitting in her recliner in her room. She indicated she had a fall at	F 0689	F0689 Requires the facility to investigate a fall for residents reviewed for accidents. 1. Resident #90 was sent to ER for evaluation and treatment. Resident placed on therapy once returning from the hospital. 2. All residents have the potential to be affected. Nurse's notes were reviewed for the last 90 days	08/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	home and broke her wrist, multiple ribs, and one side of her collar bone. While in the facility she had a fall that sent her to the hospital. Her family member was with her, and she was trying to move to her recliner from her wheelchair when she fell. She hit her left side. She lost consciousness for a while and was sent to the hospital. She stayed at the hospital for about four days. During an interview on 07/11/23 at 2:26 P.M., RN 14 indicated the resident had admitted to the facility with a broken collar bone, radial fracture, and broken ribs. She had an unsteady gait. Since she admitted to the facility, she had a fall that resulted in her going to the hospital. The family member was with the resident at the time of the fall. LPN (Licensed Practical Nurse) 15 was on duty the night of the fall. During an interview on 07/11/23 at 2:42 P.M., LPN 15 indicated on the night of the incident on June 11th, she was at the medication cart when she heard the family member's voice call out to the resident. She and a CNA (Certified Nurse Aide) started going to the room at the same time. Resident 90 was lying on the floor on her left side and was unresponsive but breathing. The family member indicated the resident had just fell to the floor like a tree falling to the ground. She obtained the residents vital signs and called 911. By the time the emergency transport arrived the resident had regained consciousness. She was alert with slurred speech. The resident was admitted to the hospital with a brain bleed and a broken clavicle. When a resident had a fall, the nurse would complete a fall report and then submit it to the DON (Director of Nursing). She wasn't sure that she completed a fall report for the resident's fall. But she did complete a nurse note.		to ensure any accidents documented were addressed and appropriate interventions were in place. No further concerns were noted. See below for corrective measures. 3. The accident and incident report and investigation report was reviewed with no changes made. (See attachment G) The staff was inserviced on the above procedure. 4. The DON or designee with review all nursing notes to ensure all accidents are investigated and have appropriate interventions completed per regulatory guidance. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. If compliance is not obtained or maintained, one on one re-education will occur with the DON to ensure she is thoroughly monitoring the documentation to ensure all accidents are investigated and proper interventions are in place per regulatory guidance. The administrator would also be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	The clinical record for the resident was reviewed on 07/10/23 at 11:28 A.M. A Significant Change MDS (Minimum Data Set) assessment, dated 06/20/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Parkinson's disease, malnutrition, anxiety, and depression. A Nurse Note, dated 05/11/23 (06/11/23 per LPN 15) at 3:45 P.M., indicated the nurse was in the hallway and she heard a noise and a man asking for help. The nurse went to the resident's room and the resident was lying on their left side, unresponsive with pursed lip breathing. The family member was in the room with the resident at the time of the incident and indicated the resident was standing to sit in the recliner from her wheelchair and she fell to the ground. The resident's blood pressure was 167/78, pulse was 92, respirations were 18, and the oxygen was 94%. She called 911 and the resident had regained consciousness prior to the emergency personnel arriving. The resident was able to answer questions appropriately with slurred speech. The DON and MD had been made aware. A hospital record, dated 06/11/23, indicated the resident was getting up and had a fall and hit her head and lost consciousness. She denied significant headache or dizziness. There were no changes in her vision. She complained of clavicle discomfort. A Hospital Discharge Summary, dated 06/15/23, indicated the resident discharge diagnoses included, but were not limited to: - acute intraparenchymal hemorrhage along the left frontal convexity, and - bilateral clavicle fracture, she had initially broken		responsible to monitor the nursing note documentation at this time to help ensuring all accidents are investigated and proper interventions are in place. 5. The above corrective measures will be completed on or before August 7, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	the left side approximately 6 weeks ago and broke the right side from a fall on 06/11/23. The clinical record lacked a documented fall incident report or investigation. During an interview on 07/11/23 at 3:03 P.M., the DON indicated a fall report was not completed for the fall and should have been. 3.1-45(a)(1)			
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's 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 follow appropriate infection control guidelines related to urinary catheters for a resident who had a history of urinary tract infections for 1 of 2 residents reviewed for urinary catheters/UTIs. (Resident 58) Findings include: During a continuous observation and interview on 07/06/23 at 1:37 P.M., Resident 58 was sitting in a recliner in his room. His urinary catheter bag was hanging on the side of a small trash can that was sitting next to his chair. The bottom inch or two of the urinary catheter bag was in a wash pan that was sitting on the floor next to the trash can. At 1:43 P.M., Student Nurse Aide 2 entered the room to empty the resident's catheter bad. She donned gloves in the bathroom, checked the catheter bag, saw that it didn't have very much urine in it, decided to not empty the catheter bag, left it hanging on the side of the small trash can, and exited the room. During an interview on 07/12/23 at 10:12 A.M., the ADON indicated the resident had a urinary catheter due to his BPH (Benign Prostate Hyperplasia) and was followed by urology. Staff were trained on urinary catheter care upon hire and at least annually. The resident had had several UTI's (Urinary Tract Infections). He was	F 0690	F0690 Requires the facility to follow appropriate infection control guidelines related to urinary catheters for a resident who had a history of urinary tract infections. 1. Resident #58 catheter bag was placed on the bed frame. 2. All residents have the potential to be affected. A complete round was conducted to ensure catheter bags and tubing was properly placed on the resident's bed frame or wheelchair. No further concerns were noted. See below for corrective measures. 3. The Urinary Catheter policy and procedure was reviewed with no changes made. (See attachment H) The staff was inserviced on the above procedure. 4. The DON or designee will conduct rounds twice a day to ensure catheter bags and tubing is properly placed on the bed frame or wheelchair. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance	08/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	admitted with one and was currently on an antibiotic a preventative measure. The catheter bag should be hanging below the bladder and not on the floor. Catheters should be hanging on the frame of the bed in a privacy bag. When up in a recliner the bag should not be hanging on a trash can. It could be placed in a wash basin free of contaminants. The clinical record was reviewed on 07/11/23 at 10:20 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 05/16/23, indicated the resident was moderately cognitively impaired. The resident had an indwelling catheter and was occasionally incontinent of bowel. The diagnoses included, but were not limited to, cancer, heart failure, obstructive uropathy, and a UTI in the last 30 days. The current urinary catheter Care Plan was provided by the Regional Director on 07/12/23 at 11:05 A.M. The Care Plan indicated the goal was for the resident to be free from signs and symptoms of infection. The resident had a current physician's order for Macrodantin, an antibiotic, 50 mg at bedtime with a start date of 05/17/23, for lower urinary tract symptoms and the following order history for antibiotics for a UTI: - Doxycyline 100 mg twice a day from 06/21/23 to 06/28/23, - Macrobid 100 mg every 12 hours from 04/30/23 to 05/05/23, - Macrobid 100 mg every 12 hours from 04/24/23 to 04/29/23, and - Macrobid 100 mg every 12 hours from 03/15/23 to 03/22/23.		is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. **If compliance is not obtained or maintained, the nursing staff will be re-educated one on one to ensure their knowledgeable about proper placement of the catheter bag and tubing in helping prevent UTI. Increased monitoring will occur three times a day if warranted as well.** 5. The above corrective measures will be completed on or before August 7, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	The current Urinary Catheter policy, dated 10/2014, was provided by the Regional Director on 07/12/23 at 1:25 P.M. The policy indicated, "...Care provided for an indwelling catheter will promote good hygiene and reduce the potential for infection..." 3.1-41(a)(2)			
F 0757 SS=E Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to follow the physician's orders related to hold parameters for hypertension medications for 3 of 7 residents reviewed for unnecessary medications. (Residents 43, 18, and 24)	F 0757	F0757 Requires the facility to follow the physician's orders related to hold parameters for hypertension medication. 1. Resident #43, #18 and #24's	08/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	Findings include: 1. The clinical record for Resident 43 was reviewed on 07/10/23 at 10:17 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 04/06/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, vertigo, hypertension, epistaxis (nose bleed), anxiety, and diabetes. The June and July 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration) indicated the resident had the following physician's orders: An open-ended physician's order, with a start date of 06/28/23, for Losartan 50 mg (milligrams) at bedtime, for hypertension, hold (do not give) for SBP (Systolic Blood Pressure, the top number) less than 130. The record indicated the resident received the medication when the blood pressure was too low per the physician's order on the following dates: - On 07/10/23 the resident's blood pressure was 117/72, - On 07/09/23 the resident's blood pressure was 124/61, - On 07/08/23 the resident's blood pressure was 123/60, and on - On 06/29/23 the resident's blood pressure was 99/64. A physician's order, with a start date of 03/01/23 and a discontinued date of 06/28/23, indicated the resident received Losartan 50. The staff were to hold the resident's medication for a SBP less than 130. The record indicated the resident received the medication when the blood pressure was too low		parameters were reviewed and no changes made at this time. 2. All residents have the potential to be affected. Resident's hold parameters were reviewed. No further concerns were noted. See below for corrective measures. 3. The Medication administration policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure. 4. The DON or designee will review all medication administration records to ensure that the hold parameters for residents on a hypertensive medication are being followed. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. **If compliance is not obtained or maintained, the nursing staff will be re-educated one on one to ensure they are knowledgeable about following hold parameters for hypertensive medication based on physician orders. Increased monitoring of the medication**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	per the physician's order on the following dates: - On 06/25/23 the resident's blood pressure was 124/61, - On 06/23/23 the resident's blood pressure was 108/77, - On 06/10/23 the resident's blood pressure was 124/59, - On 06/08/23 the resident's blood pressure was 129/72, - On 06/06/23 the resident's blood pressure was 102/63, and - On 06/04/23 the resident's blood pressure was 122/64. The Nurse's Notes for June and July 2023 lacked documentation the medication was held per the physician's orders. The resident's current Care Plan for hypertension was provided by the Regional Director on 07/12/23 at 1:25 P.M. Interventions included, but were not limited to, "...Monitor blood pressure routinely and notify physician and resident representative per call order parameters..." During an interview on 07/12/23 at 10:06 A.M., the ADON (Assistant Director of Nursing) indicated when a resident had a hold parameter it would be placed in the order for the specific medication. The medication should have been held per the physician's orders. If staff held a medication the EMAR would prompt them to choose a reason and that reason will be posted on the EMAR. 2. The clinical record for Resident 18 was reviewed on 07/10/23 at 2:04 P.M. A Quarterly MDS assessment, dated 05/30/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, heart		**administration records will occur twice a day if warranted as well to ensure parameters are being followed per physician's orders.** 5. The above corrective measures will be completed on or before August 7, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	failure, anemia, hypertension, Alzheimer's dementia, malnutrition, anxiety, depression, and respiratory failure. An open-ended physician's order, with a start date of 05/23/23, indicated the resident was to receive metoprolol 50 mg, every 12 hours for hypertension. The medication was to be held if the systolic blood pressure was less than 120 or the heart rate was less than 60. The June and July 2023 EMAR/ETAR indicated the medication was administered to the resident on the following dates and times when the systolic blood pressure was less than 120: - On 06/02/23 at 7:00 A.M. when the resident's blood pressure was 100/61 and at 7:00 P.M. when the resident's blood pressure was 118/63, - On 06/03/23 at 7:00 P.M. when the resident's blood pressure was 112/67, - On 06/04/23 at 7:00 P.M. when the resident's blood pressure was 118/72, - On 06/05/23 at 7:00 A.M. when the resident's blood pressure was 110/74 and at 7:00 P.M. when the resident's blood pressure was 118/68, - On 06/07/23 at 7:00 A.M. when the resident's blood pressure was 118/68, - On 06/08/23 at 7:00 A.M. when the resident's blood pressure was 107/46, - On 06/09/23 at 7:00 P.M. when the resident's blood pressure was 112/74, - On 06/10/23 at 7:00 A.M. when the resident's blood pressure was 113/72, - On 06/11/23 at 7:00 P.M. when the resident's blood pressure was 116/67, - On 06/13/23 at 7:00 A.M. when the resident's blood pressure was 112/76 and at 7:00 P.M. when the resident's blood pressure was 112/76, - On 06/14/23 at 7:00 A.M. when the resident's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	blood pressure was 118/74, - On 06/20/23 at 7:00 A.M. when the resident's blood pressure was 112/78, - On 06/21/23 at 7:00 A.M. when the resident's blood pressure was 93/42, - On 06/23/23 at 7:00 A.M. when the resident's blood pressure was 112/72, - On 06/28/23 at 7:00 P.M. when the resident's blood pressure was 118/71, - On 06/29/23 at 7:00 A.M. when the resident's blood pressure was 118/71, and at 7:00 P.M. when the resident's blood pressure was 112/69, - On 07/05/23 at 7:00 A.M. when the resident's blood pressure was 119/68, - On 07/06/23 at 7:00 A.M. when the resident's blood pressure was 112/70 and at 7:00 P.M. when the resident's blood pressure was 116/78, - On 07/07/23 at 7:00 A.M. when the resident's blood pressure was 118/74, and - On 07/10/23 at 7:00 A.M. when the resident's blood pressure was 85/42. The nurse notes were reviewed and lacked documentation the medication was held on the above dates and times. 3. The clinical record for Resident 24 was reviewed on 07/10/23 at 1:37 P.M. A Quarterly MDS assessment, dated 04/26/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, cancer, anemia, heart failure, hypertension, anxiety, depression, and respiratory failure. A physician's order, dated 06/07/23 through 07/10/23, indicated the staff were to administer the resident's metoprolol 25 mg once a day for hypertension. The medication was to be held if the systolic blood pressure was less than 120 or the pulse was less than 60.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	The June and July 2023 EMAR/ETAR indicated the medication was administered to the resident on the following dates when the systolic blood pressure was less than 120: - On 06/09/23 when the resident's blood pressure was 117/98, - On 06/10/23 when the resident's blood pressure was 107/58, - On 06/13/23 when the resident's blood pressure was 114/74, - On 06/19/23 when the resident's blood pressure was 98/65, - On 06/20/23 when the resident's blood pressure was 83/49, - On 06/25/23 when the resident's blood pressure was 100/54, - On 06/28/23 when the resident's blood pressure was 107/65, - On 06/29/23 when the resident's blood pressure was 92/54, - On 07/05/23 when the resident's blood pressure was 95/87, and - On 07/08/23 when the resident's blood pressure was 92/60. The nurse notes were reviewed and lacked documentation the medication was held on the above dates. An open-ended physician's order, with a start date of 04/27/23, indicated the staff were to administer the resident's midodrine 10 mg, three times a day, for hypotention. The medication was to be held if the systolic blood pressure was greater than 130. The June EMAR/ETAR indicated the medication was administered to the resident on the following			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	dates and times when the systolic blood pressure was greater than 130: - On 06/02/23 at 7:30 P.M., when the resident's blood pressure was 131/68, - On 06/16/23 at 7:30 A.M., when the resident's blood pressure was 147/62, - On 06/21/23 at 3:30 P.M., when the resident's blood pressure was 136/62, - On 06/22/23 at 7:30 P.M., when the resident's blood pressure was 149/45, - On 06/23/23 at 3:30 P.M., when the resident's blood pressure was 140/60, - On 06/26/23 at 7:30 P.M., when the resident's blood pressure was 134/63, - On 06/27/23 at 7:30 P.M., when the resident's blood pressure was 143/61, and - On 06/29/23 at 7:30 P.M., when the resident's blood pressure was 146/69. The nurse notes were reviewed and lacked documentation the medication was held on the above dates. The current facility policy titled, "Medication Administration" with a revision date of 4/2017 and was provided by the Regional Director on 07/12/23 at 2:07 P.M. The policy indicated, "...To safely administer medications as per physicians' orders...Always take pulse and B/P as indicated if ordered prior to giving certain cardiac or antihypertensive drugs. Notify the physician if the vital signs are not within the acceptable range..." 3.1-48(a)(3)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	§483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to follow infection control guidelines during assisted dining for 3 of 7 residents observed during 2 of 2 dining observations. (Residents 31, 72, and 39) Findings include: During an observation on 07/06/23 at 12:21 P.M., CNA (Certified Nurse Aide) 11 was leaning on a table with her arms and upper chest resting on the table in the assisted dining room playing some cards with Resident 72. She sat the cards on the table when Resident 31's food arrived at the table. She removed the plastic wrap off the resident's sandwich and handed it to her, without touching the bread. She unwrapped the silverware, placed a spoon on the table, replaced the cards in the box,	F 0812	F0812 Requires the facility to follow infection control guidelines during assisted dining. 1. Resident #31, #72 and #39 was assisted with eating after the nursing personnel washed their hands. 2. All residents have the potential to be affected. All nursing staff was inserviced immediately about meal service and the need to sanitize their hands if touching themselves or another resident's items prior to assisting with eating. No further concerns were noted. See below for corrective measures. 3. The Glove Use and Meal	08/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	and sanitized her hands. She picked the spoon up, placed it in the resident's ice cream, grabbed the arms of the chair she was sitting in and moved the chair, retrieved a straw, sat back down, placed the straw in the resident's drink, scooted her chair in with both hands, touched the resident's clothing protector, placed her hands in her lap, touched the resident's fork with her right hand and stirred the food. She touched the napkin with her right hand and then placed it in her left hand, scratched the top of her right leg with her right hand, and took the sandwich from the resident with her right hand in the napkin. CNA 11 gave the resident some bites of her food with her right hand on the fork and then sat it on the plate. She took both her hands and rubbed the tops of her legs to her knees then continued feeding the resident her food and her ice cream. During an observation on 07/13/23 at 12:24 P.M., CNA 11 entered the assisted dining room, picked up the jacket sitting on a chair and table and put it on. She sat down at the table with Resident 39 and rubbed her nose with her bare hand. The DON (Director of Nursing) instructed her to sanitize her hands. She then started assisting Resident 31 with her meal using her right hand. The DON had been giving Resident 72 drinks while holding the straw in her right hand. When the DON left the room CNA 11 gave Resident 72 drinks by holding her straw and fixed the resident's clothing protector. She went back and picked up Resident 39's spoon with her right hand and sat it down when the DON instructed her to sanitize her hands. During an interview on 07/13/23 at 1:45 P.M., CNA 12 indicated when assisting residents with eating you should never touch anything such as your facemask, hair, or clothes. If you do touch any of those things, you should wash or sanitize your		Service policy and procedures were reviewed with no changes made. (See attachment I and J) The staff was inserviced on the above procedures. 4. The DON or designee will observe one meal service a day to ensure infection control is being maintained feeding the residents. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. **If compliance is not obtained or maintained, the nursing staff will be re-educated one on one to ensure they are knowledgeable about how to properly feed a resident while maintaining proper infection control. Increased monitoring will occur to two meal services a day being observed if warranted as well.** 5. The above corrective measures will be completed on or before August 7, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	hands. You should never go between residents and assist with feeding unless you sanitize your hands between residents. The current, undated, facility policy titled, "Glove Use & Meal Service" was provided by the Regional Director on 07/13/23 at 2:27 P.M. The policy indicated, "...Hands should be washed thoroughly between tasks..." 3.1-21(i)(3)			
F 9999 Bldg. 00	FAILURE TO REPORT UNUSUAL OCCURRENCE (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including but were not limited to, any: (D) major accidents Based on observation, interview, and record review, the facility failed to report an accident resulting in a fracture in a timely manner for 1 of 4 residents reviewed for accidents. (Resident 90) Findings include:	F 9999	F9999 Requires the facility to report an accident resulting in a fracture in a timely manner. 1. Resident #90 accident was reported to the Indiana State Department of Health. 2. All residents have the potential to be affected. The last 90 days of Nurse's notes were reviewed to ensure all accidents meeting reportable guidance were reported to the Indiana Department of Health. No concerns were noted. See below for corrective measures. 3. The Reportable Incidents policy and procedure was reviewed with no changes made. (See attachment K) The staff was inserviced on the above procedure. 4. The corporate nurse consultant or her designee will review all nursing notes ensuring that accidents meeting reportable guidance are reported to the	08/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	During an observation and interview on 07/10/23 at 10:35 A.M., Resident 90 was sitting in her recliner in her room. While in the facility she had a fall that sent her to the hospital. Her family member was with her, and she was trying to move to her recliner from her wheelchair when she fell. She hit her left side. She lost consciousness for a while and was sent to the hospital. During an interview on 07/11/23 at 2:26 P.M., RN 14 indicated since the resident was admitted to the facility, she had a fall that resulted in her going to the hospital. A family member was with her at the time of the fall. LPN (Licensed Practical Nurse) 15 was on duty the night of the fall. During an interview on 07/11/23 at 2:42 P.M., LPN 15 indicated on the night of the incident on June 11th, she was at the medication cart when she heard a family member calling out. She and a CNA (Certified Nurse Aide) started going to the room at the same time. Resident 90 was lying on the floor on her left side and was unresponsive but breathing. The family member indicated the resident had just fell to the floor like a tree falling to the ground. She obtained the resident's vital signs and called 911. By the time the emergency transport arrived the resident had regained consciousness. She was alert with slurred speech. The resident was admitted to the hospital with a brain bleed and a broken clavicle. When a resident had a fall, the nurse would complete a fall report and then submit it to the DON (Director of Nursing). She wasn't sure that she completed a fall report for the resident's fall. But she did complete a nurse note. The clinical record for the resident was reviewed on 07/10/23 at 11:28 A.M. A Significant Change MDS (Minimum Data Set) assessment, dated		Indiana State Department of Health in a timely manner. The nurse consultant will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. If compliance is not obtained and maintained, the nurse consultant will re-educate the nursing administration and administrator on the reportable guidance regarding accidents. Increased monitoring will occur with the regional director also reviewing the nurse's notes ensuring that accidents meeting reportable guidance are reported to the Indiana Department of Health if warranted as well. 5. The above corrective measures will be completed on or before August 7, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	06/20/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Parkinson's disease, malnutrition, anxiety, and depression. A Nurse Note, dated 05/11/23 (06/11/23 per LPN 15) at 3:45 P.M., indicated the nurse was in the hallway and she heard a noise and a man asking for help. The nurse went to the resident's room and the resident was lying on their left side, unresponsive with pursed lip breathing. The family member was in the room with the resident at the time of the incident and indicated the resident was standing to sit in the recliner from her wheelchair and she fell to the ground. The resident's blood pressure was 167/78, pulse was 92, respirations were 18, and the oxygen was 94%. She called 911 and the resident had regained consciousness prior to the emergency personnel arriving. The resident was able to answer questions appropriately with slurred speech. The DON and MD had been made aware. A hospital record, dated 06/11/23, indicated the resident was getting up and had a fall and hit her head and lost consciousness. She denied significant headache or dizziness. There were no changes in her vision. She complained of clavicle discomfort. A Hospital Discharge Summary, dated 06/15/23, indicated the resident discharge diagnoses included, but were not limited to, - acute intraparenchymal hemorrhage along the left frontal convexity, and - bilateral clavicle fracture, she had initially broken the left side approximately 6 weeks ago and broke the right side from a fall on 06/11/23.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(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
	The State reportable's were requested during the survey 07/06/23 through 07/13/23. The reportable incidents lacked and investigation for the resident's fall on 06/11/23 until 07/11/23. During an interview on 07/11/23 at 3:03 P.M., the DON indicated a fall report was not completed for the fall and should have been. The current facility policy, titled "Reportable Incidents" with a revision date of 11/2016, was provided by the Regional Director on 07/13/23 at 12:07 P.M. The policy indicated, "...To ensure that reportable incidents are recorded and monitored to facilitate compliance with state and federal regulations...All incidents that qualify as reportable incidents will be reported to the Indiana State Department of Health immediately..." The current facility policy, titled "Unusual Occurances" with a revision date of 06/2023, was provided by the Regional Director on 07/13/23. The policy indicated, "...This facility shall ensure the division is immediately informed via the Gateway Online Reporting System, of unusual occurrences that directly threaten the welfare, safety or health of the resident or residents, including but not limited to, any:...major accidents..."			