		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155133	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/03/2024	
NAME OF PROVIDER OR SUPPLIER BELMONT HEALTH & REHABILITATION, THE			540 BE	ADDRESS, CITY, STATE, ZIP COD LMONT DRIVE MBUS, IN 47201		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		1
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY I	DATE	
F 0000 Bldg. 00	IN00432542, IN004 IN00433659. Complaint IN00432 the allegations were Complaint IN00433 the allegations were Complaint IN00433 related to the allega Complaint IN00433 related to the allega F755. Survey dates: May Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 117 Total: 117 Census Payor Type Medicare: 13 Medicaid: 82 Other: 22 Total: 117 These deficiencies is accordance with 416	274 - No deficiencies related to e cited. 2423 - Federal/State deficiency tion is cited at F690. 2659 - Federal/State deficiencies tions are cited at F690 and 1, 2, and 3, 2024 20058 25133 283340	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 the statement of deficiencies. plan of correction is prepared submitted because of requirer under and state and federal late Please accept this plan of correction as our credible allegation of compliance. Pleafind enclosed this plan of correction for this survey. Dut the low scope and severity of survey finding, please find the sufficient documentation provevidence of compliance with the plan of correction. The documentation serves to confithe facility's allegation of compliance. Thus, the facility respectfully requests the gran of paper compliance. Should additional information be necessary to confirm said compliance, feel free to containe.	on The and ment w. ase e to the ding he irm	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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09/20/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/03/2024 155133 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 540 BELMONT DRIVE BELMONT HEALTH & REHABILITATION, THE COLUMBUS, IN 47201 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE F 0690 483.25(e)(1)-(3) SS=D Bowel/Bladder Incontinence, Catheter, UTI Bldg. 00 Based on interview and record review, the facility F 0690 F690The facility will collect a urine 05/20/2024 failed to collect a urine sample in a timely manner, sample in a timely manner, and and notify the physician or attempt interventions notify the physician if a resident for a resident's refusal of antibiotic administration refuses an antibiotic related to a Urinary Tract Infection for 1 of 3 administration. residents reviewed for Urinary Tract Infections. 1. Resident B urine sample was (Resident B) collected and was being treated for a urinary tract infection. Findings include: 2. All residents have the potential to be affected. A complete audit The clinical record for Resident B was reviewed was conducted to ensure all urine on 05/02/24 at 9:48 A.M. An Admission MDS sample was collected and being assessment, dated 01/17/24, indicated the resident treated per physician orders. No was severely cognitively impaired, occasionally refusals were noted. incontinent of bladder and frequently incontinent 3. The staff was inserviced that a of bowel. The diagnoses included, but were not urine sample has to be collected limited to, stroke, dementia, Alzheimer's disease, within 24 hours of the physician's seizure disorder, chronic pain, and anxiety. order and if a resident refuses an antibiotic that the physician/nurse The EMAR/ETAR for February and March 2024, practitioner is immediately related to the resident's UTIs were provided by notified. 4. The DON or her designee will the DON on 05/03/24 at 1:50 P.M., and included, but were not limited to, the following physician's review all physician orders daily to orders for specimen collection and antibiotics: ensure urine samples are collected with 24 hours of the The physician's order, with a start date of physician orders and that if a 02/02/24, on day shift with a discontinued dated resident refuses their antibiotic of 02/06/24, indicated staff were to collect the that the physician/nurse specimen as soon as possible. The specimen was practitioner is notified not collected until 02/05/24 on night shift. immediately. The DON or her designee will utilize the nursing The resident was prescribed Macrobid 100 mg monitoring tool daily times four twice a day from 02/08/24 to 02/14/24. weeks, then weekly times four weeks, then every two weeks

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dates and times:

The record indicated the resident's medication of

Macrbid was not administered on the following

Event ID:

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times two months, then quarterly

thereafter until 100% compliance

is obtained and maintained. (See

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CENTERS FOR	MEDICARE & MEDIC				ONIB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>		COMPLETED	
		155133	B. WING		05/03/2024	
		1	 _		l	
NAME OF P	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD		
				LMONT DRIVE		
BELMON	IT HEALTH & REH	ABILITATION, THE	COLUN	/IBUS, IN 47201		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
1/10	REGULATORI OF	CLOC IDENTIFIEND INFORMATION	IAU	attachment A) The audits will	5.11.5	
	On 02/10/24 6:30) A.M 2:30 P.M., with the		reviewed during the facility's	De	
				,		
		listed as, "Refused", the		quarterly quality assurance		
	_	AR was completed at 2:39		meetings and the plan of		
	P.M.,			correction will be adjusted		
	0.00/10/04 600) A M. (2.20 P.M. (23.2)		accordingly if warranted. If		
) A.M 2:30 P.M., with the		compliance is not obtained or		
		listed as, "Due to Condition",		maintained, the staff member		
	_	EMAR was completed at 11:14		be re-educated one on one ar		
	A.M.,			additional monitoring will occu	•	
				the DON or her designee revi	-	
	· ·	P.M 10:30 P.M., with the		the physician orders once a s	hift	
		listed as, "Due to Condition",		to ensure urine samples are		
	_	EMAR was completed at 4:22		collected within 24 hours and	-	
	P.M.,			refusals of an antibiotic is rep		
				to the physician/nurse practiti	oner	
	- On 02/13/24, 6:30	0 A.M 2:30 P.M., with the		immediately.		
	Reason/Comments	listed as, "Due to Condition",		5. The above corrective meas	sures	
	the charting on the	EMAR was completed at 12:54		will be completed on or before	e	
	P.M.,			May 20, 2024.		
	- On 02/14/24, 6:30	A.M 2:30 P.M., with the				
	Reason/Comments	listed as, "Due to Condition",				
	the charting on the	EMAR was completed at 10:33				
	A.M., and	-				
	- On 02/14/24, 2:30	P.M 10:30 P.M., with the				
	1	listed as, "Refused", the				
		AR was completed at 10:47				
	P.M.					
	The physician's ord	ler, with a start date of 02/19/24				
		date of 02/19/24, indicated the				
		collected as soon as possible.				
	_	tions indicated the order could				
	1 ^	en the specimen was				
	collected.	ten die speemen was				
	conceicu.					
	The recident was as	rescribed Ciprofloxacin				
	_	-				
	(antibiotic) 230 mg	twice a day from 02/22/24 to	1	1	ĺ	

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Event ID:

B04P11

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AND PLAN OF CORRECTION Total Tota	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER BELMONT HEALTH & REHABILITATION, THE (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR ISC IDENTIFYING INFORMATION O228/24. The clinical record indicated the resident's medication (Ciprolloxacin) was not administered on the following dates and times: - On 02/22/24, 2:30 P.M 10:30 P.M., with the Reason/Comments listed as, "Fabre of Condition", the charting on the EMAR was completed at 2:12 P.M., and - On 02/26/24, 2:30 P.M 10:30 P.M., with the Reason/Comments listed as, "Other" and "3'ni", the charting on the EMAR was completed on 02/27/24 at 11:42 A.M. The physician's order, with a start date of 03/22/24 and a discontinued date of 03/23/24, indicated staff were to dip the resident's urine and if the urine dip test was positive they were to send the resident's urine for a Urinalysis with C&S as soon as possible. The special instructions indicated the order could be discontinued when the specimen was collected. The resident was prescribed Bactrim 800-160 mg twice a day from 03/24/24 to 03/30/24. The record indicated the medication was not administered on the following dates and times: - On 03/28/24, 6:30 A.M 10:30 A.M., with the Reason/Commens listed as, "Refused", the charting on the EMAR was completed at 7:15	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
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administered on the following dates and times: - On 03/28/24, 6:30 A.M 10:30 A.M., with the Reason/Comments listed as, "Refused", the charting on the EMAR was completed at 7:15		The record indicate	d the medication was not					
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Reason/Comments listed as, "Refused", the charting on the EMAR was completed at 7:15		administrated on the	Terre wing dutes dild tillies.					
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charting on the EMAR was completed at 7:15								
		-						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

B04P11

Facility ID: 000058

If continuation sheet Page 4 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155133	B. WI	/2024			
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					LMONT DRIVE		
BEL MON	JT HEALTH & REH	ABILITATION, THE			1BUS, IN 47201		
DELINO	·	ABIETTATION, THE		OOLON	1000; 114 47201		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN O			
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	- On 03/29/24, 6:30 A.M 10:30 A.M., with the Reason/Comments listed as, "Refused", the charting on the EMAR was completed at 7:29 A.M. The resident's Mood and Behavior record lacked documentation of a specific time or interventions attempted for the resident's refusal of antibiotic administration, and there were no documented physician notification of the resident's refusals on the following dates: 02/10/24, 02/12/24, 02/13/24, 02/14/24, 02/22/24, 02/26/24, and 03/28/24. During an interview on 05/03/24 at 12:25 P.M., LPN (Licensed Practical Nurse) 2 indicated when getting a UA, she would hope the specimen would be collected within 24 hours of receiving the order. If a resident needed to be straight cathed it would be part of the physician's order. During an interview on 05/03/24 at 1:50 P.M., the DON indicated they did not have a policy on collecting urine specimens. This citation relates to Complaints IN00433423 and IN00433659.						
	3.1-41(a)(2)						
F 0755 SS=D Bldg. 00	Based on observation	/Pharmacist/Records on, interview, and record failed to provide prescribed	F 07	755	F755The facility will provide prescribed medications for		05/20/2024
		f 5 residents reviewed for			residents reviewed for pharma services. 1. Resident F medication was obtained and given per physic orders.		

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039								
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
		155133	B. W	ING		05/03	/2024	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ELMONT DRIVE			
DELMON		ABILITATION THE						
BELIVION	NI HEALIH & KEH	ABILITATION, THE		COLUMBUS, IN 47201				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	During an observat	ion and interview on 05/02/24			2. All residents have the pote	ential		
		ent F was sitting in their room			to be affected. A complete a	udit		
	in a recliner. The re	esident indicated there were			was conducted to ensure all			
	times when they ha	d not been getting their			resident's medication were			
	medications like the	ey were supposed to.			available from the pharmacy	to be		
					given per the physician's ord			
	The clinical record	was reviewed on 05/02/24 at			3. The staff physician's order	•		
		rterly MDS (Minimum Data Set)			policy and procedure was rev	viewed		
		04/17/24, indicated the resident			with no changes made. (See			
	was cognitively intact. The diagnoses included, but were not limited to, heart failure, hypertension,				attachment B) The staff was			
					inserviced on the above prod			
	and renal insufficiency.				4. The DON or her designee will			
					review all medication			
		(Electronic Medication			administration records daily t	.0		
		cord/Electronic Treatment			ensure that medications are			
		cord) for January 2024 was		administered per the physician's				
		ON on 05/03/24 at 11:08 A.M.			orders. The DON or her desi	gnee		
		physician's order for			will also review 5 resident's			
		water pill), 40 milligrams, twice			medications daily to ensure a			
		sion, with a start date of			medications are reordered in			
	01/27/23 and a disc	continued date of 01/31/24.			timely manner. The DON or I			
					designee will utilize the nursi	-		
		rd indicated the medication			monitoring tool daily times fo			
	was not administered	ed on the following dates and			weeks, then weekly times for			
	times:				weeks, then every two weeks			
					times two months, then quar	•		
		30 P.M 1:00 P.M., with the			thereafter until 100% complia	ance		
		listed as, "Other" and "days",			is obtained and maintained.	•		
	_	EMAR was completed at 5:44			attachment A) The audits wil	l be		
	P.M.,				reviewed during the facility's			
	0.04/25/25				quarterly quality assurance			
) A.M 10:30 A.M., with the			meetings and the plan of			
		listed as, "Other" and			correction will be adjusted			
		rting on the EMAR was			accordingly if warranted. If			
	completed at 2:15 I	P.M.,			compliance is not obtained o			
					maintained, the staff membe			
) A.M 10:30 A.M., with the			be re-educated one on one a			
	Reason/Comments listed as, "Other" and				the DON or her designee will			

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completed at 2:06 P.M.,

"detained", the charting on the EMAR was

Event ID:

B04P11

Facility ID: 000058

If continuation sheet

review two halls daily to ensure all

medications are present and

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PRINTED: 09/20/2024

DEPARTMENT		FORM APPROVED OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155133		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/03/2024	
NAME OF PROVIDER OR SUPPLIER BELMONT HEALTH & REHABILITATION, THE			STREET ADDRESS, CITY, STATE, ZIP COD 540 BELMONT DRIVE COLUMBUS, IN 47201				
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) reordered in a timely manner. 5. The above corrective meas will be completed on or before May 20, 2024.	ures	(X5) COMPLETION DATE
	the charting on the P.M., and On 01/27/24, 12:3 Reason/Comments the charting on the P.M. The complete Care on 5/03/24 at 2:08 of for hypertension, wincluded, but was nadminister, "furose: During an interview DON indicated the physician's orders.	listed as, "Other" and "days", EMAR was completed at 2:40 30 P.M 1:00 P.M., with the listed as, "Other" and "days", EMAR was completed at 2:21 Plan was provided by the DON P.M. The resident's plan of care ith a reviewed date of 03/01/24, ot limited to, an intervention to mide per MD order". v on 05/03/24 at 10:35 A.M., the staff should follow the No explanation was provided sons/Comments" on the					
	EMAR. The current "PHYS	SICIAN ORDERS" policy, dated					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

10/2014, was provided by the DON on 05/03/24 at 1:50 P.M. The policy indicated, "...Physician's order 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

B04P11

Facility ID: 000058

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155133	(X2) MUL' A. BUIL B. WINC	DING	nstruction 00	(X3) DATE COMPL 05/03/	ETED
NAME OF PROVIDER OR SUPPLIER BELMONT HEALTH & REHABILITATION, THE			STREET ADDRESS, CITY, STATE, ZIP COD 540 BELMONT DRIVE COLUMBUS, IN 47201				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHO		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	there is any question doseright frequent attempt to contact the obtain clarification	When an order is received, if in regarding theright cythe licensed nurse will the prescribing physician to of any order in question" Ito Complaint IN00433659.					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: B04P11 Facility ID: 000058 If continuation sheet Page 8 of 8