

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2025
NAME OF PROVIDER OR SUPPLIER Belmont Health & Rehabilitation, The		STREET ADDRESS, CITY, STATE, ZIP CODE 540 Belmont Drive Columbus, IN 47201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to document meal consumption values for 8 of 10 residents reviewed for nutrition. (Residents E, F, G, H, J, B, K, and L) Finding include: 1. The clinical record for Resident E was reviewed on 09/29/2025 at 10:35 A.M. A Significant Change Minimum Data Set (MDS) assessment, dated 08/21/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure, hypertension, stroke, and Chronic Obstructive Pulmonary Disease (COPD). The August and September 2025 Meal Consumption Record lacked documented meal intake values for the following dates: - 08/27/2025 at dinner, - 08/28/2025 at dinner, - 08/29/2025 at breakfast, lunch, and dinner, - 08/30/2025 at dinner, - 08/31/2025 at breakfast and lunch, - 09/05/2025 at dinner, - 09/06/2025 at dinner, - 09/07/2025 at breakfast, lunch, and dinner, - 09/08/2025 at dinner, and - 09/09/2025 at breakfast, lunch, and dinner. 2. The clinical record for Resident F was reviewed on 09/29/2025 at 4:19 P.M. A Quarterly MDS assessment, dated 07/21/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, bipolar disease, heart failure, hypertension, diabetes, dementia, anxiety, and depression. The August and September 2025 Meal Consumption Record lacked documented meal intake values for the following dates: - 08/23/2025 at breakfast, lunch, and dinner, (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The clinical record for Resident H was reviewed on 09/25/2025 at 3:58 P.M. A Quarterly MDS assessment, dated 06/17/2025, indicated the resident was severely cognitively impaired. The resident's diagnoses included but, were not limited to, malnutrition, hypertension, diabetes, depression, and anxiety. The August and September 2025 Meal Consumption Record lacked documented meal intake values for the following dates: - 08/01/2025 at dinner, - 08/04/2025 at dinner, - 08/05/2025 at lunch and dinner, - 08/09/2025 at breakfast, lunch, and dinner, - 08/10/2025 at breakfast and lunch, - 08/16/2025 at dinner, - 08/22/2025 at dinner, - 08/23/2025 at breakfast, lunch, and dinner, - 08/24/2025 at breakfast, lunch, and dinner, - 08/27/2025 at dinner, - 08/28/2025 at dinner, - 08/30/2025 at dinner, - 08/31/2025 at dinner, - 09/03/2025 at dinner, - 09/05/2025 at dinner, - 09/06/2025 at breakfast and lunch, and - 09/07/2025 at dinner. 5. During an interview, on 09/26/2025 at 1:57 P.M., Resident J indicated he always ate breakfast, lunch, and dinner in the facility. He had not left the facility and eaten somewhere else. He always ate his meals in his room. The resident's clinical record was reviewed on 09/29/2025 at 1:30 P.M. An admission MDS assessment, dated 09/05/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure, diabetes, and coronary artery disease. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The September 2025 Meal Consumption Records lacked documented meal consumptions for the following dates: -09/07/2025 at breakfast, and lunch, -09/09/2025 at breakfast, and lunch, -09/15/2025 at dinner, -09/17/2025 at dinner, -09/19/2025 at dinner, -09/21/2025 at dinner, -09/22/2025 at dinner, -09/24/2025 at dinner, and -09/25/2025 at dinner. 6. The clinical record for Resident B was reviewed on 09/26/2025 at 1:41 P.M. A Quarterly MDS assessment, dated 08/19/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, heart failure, wound infection, and diabetes. The August and September 2025 Meal Consumption Records lacked documented meal consumptions for the following dates: -08/01/2025 at breakfast, lunch, and dinner, -08/04/2025 at dinner, -08/05/2025 at breakfast and lunch, -08/14/2025 at lunch and dinner, -08/15/2025 at breakfast and lunch, -08/23/2025 at breakfast, lunch, and dinner, -08/24/2025 at dinner, -08/25/2025 at dinner, -08/27/2025 at dinner, -08/28/2025 at dinner, -08/29/2025 at dinner, -09/02/2025 at dinner, -09/05/2025 at dinner, -09/06/2025 at dinner -09/07/2025 at dinner, and -09/21/2025 at dinner. 7. The clinical record for Resident K was reviewed on 09/26/2025 at 11:25 A.M. A Quarterly MDS assessment, dated 09/04/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anxiety, depression, and psychotic disorder. The August and September 2025 Meal Consumption Records lacked documented meals for the following dates: -08/01/2025 at dinner, -08/02/2025 at dinner, -08/08/2025 at breakfast, lunch, and dinner, -08/09/2025 at breakfast and lunch, -08/14/2025 at dinner, -08/21/2025 at dinner, -08/25/2025 at dinner, -08/26/2025 at dinner, -09/08/2025 breakfast and lunch, -09/17/2025 dinner, -09/20/2025 breakfast and lunch, and -09/26/2025 breakfast and lunch. 8. The clinical record for Resident L was reviewed on 09/26/2025 at 10:08 A.M. An Annual MDS assessment, dated 07/09/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, dementia, anemia, heart failure, obstructive uropathy, and (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diabetes. The August and September 2025 Meal Consumption record lacked documented meals for the following dates: -08/01/2025 at dinner, -08/04/2025 at dinner, -08/05/2025 at breakfast and lunch, -08/06/2025 at breakfast and lunch, -08/14/25 at lunch and dinner, -08/15/2025 at breakfast and lunch, -08/23/2025 at breakfast, lunch, and dinner, -08/27/2025 at dinner,-08/28/2025 at dinner,-08/29/2025 at dinner, -09/02/2025 at dinner, -09/07/2025 at dinner, and-09/21/2025 at dinner. During an interview, on 09/29/2025 at 10:19 A.M, QMA (Qualified Medication Aide) 5 indicated all resident meals, that included breakfast, lunch, and dinner were documented in the resident's clinical record on the computer. If the residents refused a meal or were out of the facility during the meal they were able to document, it also. The current facility policy titled, Meal Consumption Record was provided by the Assistant Director of Nursing on 09/29/25 4:35 P.M. The policy indicated, .To provide means to monitor the resident's daily intakes.Percentage of meals consumed daily will be recorded on the document designated by the facility. This citation relates to Intake 2617395. 3.1-46(a)(1)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to store medications appropriately and ensure a resident was assessed to self-administer medications for 1 of 25 residents reviewed for medications. (Resident 55) Findings include: Resident 55 was observed in her room sitting in her chair on 09/24/2025 at 11:41 A.M. A medication cup with three Tums (an antacid medication) tablets was observed on the overbed table near the resident. The resident indicated she had the medication because she had heartburn. The resident's clinical record was reviewed on 09/28/2025 at 12:05 P.M. A Comprehensive Minimum Data Set (MDS) assessment, dated 07/02/2025, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, cerebrovascular accident, coronary artery disease, and gastroesophageal reflux disease (GERD). The resident's record lacked a physician's order for the Tums medication and lacked a physician's order to self-administer medications. The resident was observed in her room sitting in her chair on 09/24/2025 at 12:16 P.M. The medication cup with the Tums tablets was still on the overbed table. The resident indicated a nurse gave her the Tums the day before. The resident was observed with Licensed Practical Nurse (LPN) 3 on 09/24/2025 at 12:24 P.M. LPN 3 indicated it looked like Tums tablets in the medication cup. She was the nurse caring for the resident and she did not leave the Tums. She thought maybe a Qualified Medication Aide left the medication. The resident's Electronic Health Record was reviewed with LPN 3 on 09/24/2025 at 12:28 P.M. LPN 3 indicated the resident didn't have a physician's order for Tums. She was not sure where the Tums came from. She looked in the medication cart and the resident did not have Tums in the cart. The resident did not have a physician's order to self-administer medications either. The medication should not have been left on the resident's overbed table. The current facility policy, titled MEDICATIONS, SELF-ADMINISTRATION, dated 09/17, was provided by the Regional Director of Operations on 09/30/2025 at 10:28 A.M. The policy indicated, the interdisciplinary team shall evaluate the resident for the ability to accomplish this task. If the evaluation reveals the resident capable of participation in self-administration, a physician's order reflecting the same shall be obtained. 3.1-11(a)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to identify and treat pressure ulcers before they progressed to Stage III (full thickness skin loss that may extend into the subcutaneous tissue) pressure ulcers for 2 of 4 residents reviewed for pressure ulcers. (Residents C and B) Findings include: 1. Resident C's coccyx wound was observed on 09/26/2025 at 2:58 P.M. The wound was pea-sized, with a dark pink wound bed and lighter pink skin around the wound. There was no drainage or signs of infection. The resident's clinical record was reviewed on 09/26/2025 at 11:11 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 09/04/2025, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, heart disease, cancer, peripheral vascular disease, and malnutrition. The resident was receiving hospice services. Both of the resident's lower extremities were impaired and the resident depended on nursing staff for all Activities of Daily Living (ADLs). The resident was at risk for developing pressure ulcers and had a Stage 3 pressure ulcer that was not present on admission. A Wound Management Detail Report, dated 06/27/2025, indicated the wound on the resident's coccyx was identified on 06/26/2025 as a Stage 3 pressure ulcer that measured 2.5 centimeters (cm) X (by) 1 cm, with a depth of 1 cm. There was a moderate amount of serosanguineous (pale red to pink, thin and watery) drainage. The wound bed was covered with 100% granulation (new, pink/red moist) tissue. There was 0.5 cm of undermining (a separation of the wound edge from the surrounding healthy tissue) present. The resident's shower sheets and hospice aide visit notes lacked any indication the resident had any wounds when staff provided care on 06/06/2025, 06/10/2025, 06/13/2025, 06/17/2025, or 06/24/2025. During an interview, on 09/30/2025 at 10:17 A.M., the Facility Wound Nurse indicated the wound should have been identified before it was a Stage 3 with undermining. 2. The clinical record for Resident B was reviewed on 09/26/2025 at 1:41 P.M. A Quarterly MDS assessment, dated 08/19/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, heart failure, wound infection, and diabetes. The resident had pressure ulcers at the time of the assessment. A Wound Clinic Note, dated 02/14/2025, indicated the resident had a new wound to the right lateral ankle. The wound was a Stage 3 pressure ulcer that was acquired on 02/11/2025. The wound measured 1.5 cm X 2 cm X 0.1 cm. There was fat layer exposed, with a medium amount of necrotic tissue within the wound bed including slough. A Facility Wound Management Report, indicated the resident had a Stage 3 pressure ulcer to the right lateral ankle that was identified on 02/11/2025. The Wound Management Report was created on 02/14/2025. The wound measured 1.5 cm X 2 cm X 0.1 cm. The resident had the following orders in place at the time the wound was identified: -A physician's order, dated 06/05/2024 through 03/06/2025, to perform a weekly skin inspection on Fridays. If any new areas were identified, a new skin impairment event was to be opened, and (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A physician's order, dated 02/12/2025 through 04/09/2025, to cleanse the right lateral ankle with normal saline, pat dry, apply skin prep to the peri-wound, apply moistened Prisma to base of the wound, cover with a 4 x 4 gauze, wrap with conforming rolled gauze, and secure with tape. The Event Reports lacked an assessment for the resident's right lateral ankle. The resident's shower sheets lacked any indication the resident had any wounds on 02/03/2025, 02/06/2025, or 02/10/2025. The resident's clinical record lacked documentation of the resident's wound until 02/14/2025, when it was a Stage 3 pressure ulcer. The February 2025 EMAR/ETAR lacked documentation that the right ankle treatment was completed prior to 02/14/2025. During an interview, on 09/29/2025 at 10:25 A.M., Licensed Practical Nurse (LPN) 9 indicated the nurses assessed the residents' skin weekly and it was documented in the EMAR/ETAR. The Certified Nurse Aides (CNAs) would check the residents' skin daily and would let the nurse know of any new skin impairments. The CNAs also completed shower sheets and would document the new skin impairments and let the nurse know. Once a new skin impairment was identified the nurse would measure the wound, document it in wound management and in a nurse's note, let the wound nurse know, and get a new treatment order. During an interview, on 09/29/2025 at 2:25 P.M., the Facility Wound Nurse indicated the resident's right ankle wound developed in February 2025. The wound was a Stage 3 when it was first identified. The nurses assessed residents' skin weekly in the EMAR/ETAR. If a new wound was identified, then it should be documented in a skin event and a progress note. The CNAs would document skin impairments on the shower sheets and would notify the nurse. The resident's ankle wound should have been identified before it was a Stage 3. The current facility policy, titled SKIN MANAGEMENT PROGRAM, most recently revised in 2025, was provided by the Regional Director of Operations on 09/30/2025 at 3:48 P.M. The policy indicated, .The facility will assess/identify the presence of risk factors that may contribute to the development of pressure ulcers.in an effort to prevent skin breakdown and/or further deterioration.Residents who receive assistance with bathing and/or pericare will be observed daily by nursing staff and any observance of red areas, open areas .will be reported to the licensed nurse for further assessment . This citation relates to intake 2617395. 3.1-49(a)(2)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to store medications appropriately for 1 of 4 medication carts observed (300 Hall Medication Cart). Findings include: The 300 Hall Medication Cart was observed with RN 2 on 09/30/2025 at 9:35 A.M. The following were observed in the top drawer:- A half full insulin glargine pen belonging to Resident 77 with an opened date of 09/01/2025, and - A three-fourths full insulin Aspart pen belonging to Resident 108 with an opened date of 09/01/2025. During an interview, on 09/30/2025 at 9:39 A.M., RN 2 indicated insulin pens should be dated when placed in the medication cart and once opened were good for 30 days at room temperature. The manufacture's package insert for Insulin Glargine was provided on 09/30/2025 at 10:00 A.M., by the Regional Director of Operations (RDO). The insert indicated, .Throw away the pen you are using after 28 days, even if it still has insulin left in it. The manufacture's package insert for Insulin Aspart was provided on 09/30/2025 at 10:00 A.M., by the RDO. The insert indicated, .Unused Insulin Aspart FlexPen stored at room temperature should be thrown away after 28 days. The current facility policy titled, MEDICATION EXPIRATION, was provided by the RDO on 09/30/2025 at 9:52 A.M. The policy indicated, .If a multi-dose vial has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial . 3.1-25(j)3.1-25(o)		