STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165380	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Belmond	1107 Seventh Street NE Belmond, IA 50421

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review and staff interview, the facility failed to submit a Level 2 Preadmission Screening and Resident Review (PASRR) evaluation for 1 of 1 residents reviewed with a new mental health diagnosis and start of new psychotropic medications (Resident #15). The facility reported a census of 30 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], documented Resident #15 had a Brief Interview for Mental Status (BIMS) of 9 indicating moderately impaired cognition. The MDS revealed Resident #15 had diagnoses of psychotic disorder, adjustment disorder with depressed mood and visual hallucinations. The Care Plan for Resident #15 with a target date of 7/11/24 included a focus area for mood/behavior revealed exhibited visual hallucinations. The Care Plan further documented Resident #15 received psychotropic medications for the hallucinations and depression. The Clinical record revealed Resident #15 had the following diagnoses with effective dates: 1. Adjustment disorder with depressed mood-effective 8/1/23 2. Delusional disorder- effective date 7/31/23 3. Visual hallucinations- effective date 1/26/22 The April 2024 Medication Administration Record (MAR) for Resident #15 directed staff to administer the following medications: a. Sertraline HCL (antidepressant) 25 mg (milligrams) one tablet by mouth in the morning related to adjustment disorder with depressed mood. Start date: 8/2/23 b. Risperdal (antipsychotic) 0.25mg one tablet by mouth two times a day for hallucinations/altered mental status. Start date: 5/5/23 (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Level 1 PASRR completed on 4/20/22 documented Resident #15 did not have a major mental illness. The PASRR evaluation documented Resident #15 received Ativan (antianxiety) for anxiety disorder. The clinical record revealed no additional PASRR evaluations after 4/20/22. The Clinical record review revealed Resident #15 did not have a Level 2 PASRR evaluation submitted following the new mental health diagnoses with the addition of new medications. (antidepressant and antipsychotic). On 4/23/24 at 12:45 PM, the Director of Nursing (DON) acknowledged and verified Resident 15's PASRR had not been updated. She stated her expectation for the PASRR was to be updated when there was a new diagnosis or a new classifications of medication. The DON reported the facility did not have a PASRR policy.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886 Based on clinical record review and staff interview, the facility failed to follow a physician's order for 1 of 1 residents reviewed receiving diabetic medication (Resident #14). The facility reported a census of 30 residents. Findings Include: The Minimum Data Set (MDS) dated [DATE] documented Resident #14 had a Brief Interview for Mental Status (BIMS) of 4, indicating severe cognitive impairment. The MDS further documented the resident had diagnoses to include medically complex conditions, renal insufficiency, and diabetes mellitus (DM). The Care Plan for Resident #14, with a target date of 6/25/24, documented under the focus section the resident had diabetes mellitus, with interventions to take routine insulin and a weekly injection to help control blood sugars. Review of records for Resident #14 revealed a Progress Note entry on 2/9/24 at 10:26 AM titled Physician Visit note, documented new orders received and noted from physician visit note to increase resident's Ozempic (Diabetic medication) to 1mg (milligram) once a week. Review of Progress Note entry on 2/13/24 at 10:07 PM, titled Orders-Administration Note, Ozempic (0.25 or 0.5 MG/DOSE) Subcutaneous (applied under the skin) Solution Pen-injector 2 MG/3ML, Inject 1 mg subcutaneously (under the skin) one time a day every Tuesday related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA Only 0.5mg dosage available in the pen. No other pen available. Review of the Medication Administration Record (MAR) for Resident #14 for the month of February 2024, revealed documentation on 2/13/24 of 0.5 mg of Ozempic administered. Review of Progress Note entry on 2/16/24 at 12:43 PM titled Secure Conversations, with a message sent 2/14/24 at 1:05 PM by Director of Nursing (DON) to Resident #14's physician indicating resident only received 0.5 mg Ozempic last evening as that is all that was available, new pens (Ozempic) have been ordered from pharmacy. During an interview 4/24/24 at 10:45 AM, the Director of Nursing (DON) stated Resident #14 had an order from the physician on the 9th of February of 2024 for 1 mg of Ozempic, to be given once a week every Tuesday. The DON stated Resident #14 was not given the full 1 mg of Ozempic as prescribed on Tuesday, the 13th of February. During an interview 4/24/24 at 2:38 PM, the DON advised Resident #14's order for Ozempic changed on the 9th of February, 2024, to 1 mg every Tuesday. The pharmacy did not receive the order change until the 13th and did not deliver it to the facility until the 15th of February. The DON read the Progress Note of the resident only receiving half of the prescribed dose on the 13th of February when she arrived at work on the morning of the 14th of February. The DON sent a message to the resident's physician on the 14th advising of the resident only receiving half of the prescribed dose of Ozempic. The physician replied back on the 16th of February with no new orders. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated an expectation that the nurse administering the medication reach out to the physician prior to giving the resident the incorrect dosage of the prescribed medication on the 13th of February. The DON acknowledged the physician's orders were not followed. During an interview 4/25/24 at 9:34 AM, the Administrator advised the facility does not have a policy for following physician orders, they follow professional standards and nurses are expected to follow physician orders.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on resident interviews, staff interviews, and facility records review the facility failed to provide sufficient staff to meet the needs of residents who resided in the facility (Residents #4 and #19). The facility reported a census of 30 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #4 dated 4/3/24 assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The Census tab in the clinical record revealed Resident #4 resided in room [ROOM NUMBER]. On 4/23/23 at 10:30 AM, the Administrator provided Resident #4's call light report from 3/23/24 to 4/23/24. The Administrator verified the column on the report titled In Room Elapsed Time was the duration the call light was on. On 4/23/24 at 1:05 PM, Resident #4 reported her call light can be long at times on all shifts. She stated she tried to be patient with the staff as she knew they were working with other residents. She stated she used the clock on the wall to time the call lights. In a previous interview on 4/22/24 at 1:18 PM, Resident #4 stated she had been incontinent of bowel while waiting for a call light to be answered. Review of Resident #4's call light reports for room [ROOM NUMBER] from 3/23/24 to 4/23/24 revealed the highest room elapsed time was 25 minutes and 4 seconds. The call light report documented Resident #4's call light was on 15 minutes or more on the following dates and times: 3/23 at 7:54 AM= 21 minutes and 27 seconds 3/25 at 5:53 AM= 17 minutes and 26 seconds 3/26 at 1:30 AM= 16 minutes and 13 seconds 3/26 at 8:18 AM = 16 minutes and 35 seconds 3/28 at 7:09 PM= 17 minutes and 26 seconds 4/1 at 8:13 AM= 15 minutes and 29 seconds 4/2 at 8:17 AM= 16 minutes and 2 seconds 4/4 at 7:31 AM= 15 minutes and 58 seconds 4/8 at 7:38 AM= 16 minutes and 49 seconds (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/10 at 3:29 AM= 25 minutes and 4 seconds 4/13 at 8:19 AM= 15 minutes and 32 seconds 4/14 at 11:23 AM= 15 minutes and 35 seconds 4/15 at 1:30 PM= 18 minutes and 29 seconds 4/18 at 8:14 AM= 17 minutes and 37 seconds 4/20 at 8:20 AM= 18 minutes and 57 seconds On 4/24/24 at 10:14 AM, the Director of Nursing (DON) reported her expectation was to answer the call light as soon as possible but within 15 minutes. The DON reported the facility did not have a call light policy. She stated staff learn the call light expectations through their training. 48886 2. The MDS dated [DATE] documented Resident #19 had a BIMS score of 15, indicating intact cognition. The Census tab in the clinical record revealed Resident #19 resided in room [ROOM NUMBER]. During an interview on 4/22/24 at 1:10 PM, Resident #19 reported having to wait for up to a half hour for a response to her call light, stating this has happened more than once and more so on the weekends. Resident #19 stated she used the clock in her room to time the response to call lights. On 4/23/23 at 10:30 AM, the Administrator provided Resident #19's call light report from 3/23/24 to 4/23/24. The Administrator verified the column on the report titled In Room Elapsed Time was the duration the call light was on. Review of Resident #19's call light reports for room [ROOM NUMBER] from 3/23/24 to 4/23/24 revealed the highest room elapsed time was 34 minutes and 21 seconds. The call light report documented Resident #19's call light was on 15 minutes or more on the following dates and times: 3/23 at 10:54 PM = 18 minutes and 5 seconds 3/30 at 10:49 PM = 18 minutes and 59 seconds 4/1 at 8:56 AM = 23 minutes 42 seconds 4/1 at 11:00 AM = 16 minutes and 2 seconds 4/2 at 12:21 PM = 23 minutes and 41 seconds 4/3 at 12:07 PM = 15 minutes and 45 seconds 4/5 at 10:15 AM = 17 minutes and 13 seconds (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/8 at 12:13 PM = 16 minutes and 18 seconds 4/11 at 11:19 AM = 17 minutes and 11 seconds 4/12 at 2:29 PM = 17 minutes and 25 seconds 4/15 at 7:08 AM = 16 minutes and 32 seconds 4/15 at 9:48 AM = 17 minutes and 41 seconds 4/15 at 1:15 PM = 34 minutes and 21 seconds 4/17 at 10:27 AM = 18 minutes and 19 seconds During an interview 4/24/24 at 10:30 AM, Staff B, Certified Nursing Assistant (CNA), stated all staff carry an I-phone that has the call lights on it, it shows which resident has pushed their call light and how long the light has been on, this helps her determine which resident she should go to first. Staff B will look at the call light log on her I-phone to see who has been waiting the longest for a call light response and will go to the resident waiting the longest. Inquired how and when they turn the call light off to show it was responded to, Staff B advised they turn the light off in the room when they go into the resident's room to see why they pulled their call light, and this turns it off on the call light log on the I-phone. Staff B advised they are trained to respond to call lights within 15 minutes and that is their expectation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48886 Based on observation, staff interviews and policy review, the facility failed to prepare food under sanitary conditions, in order to reduce the risk of contamination and foodborne illness. The facility reported a census of 30 residents. Findings include: During an observation on 4/24/24 at 10:50 AM, Staff A, Cook, began the puree process for residents on a pureed diet. Wearing gloves, Staff A tore chicken off the bone and placed on a scale, took the gloves off, did not wash hands, and poured the chicken into the robot coupe (machine used to puree food) container. Using bare hands, Staff A touched the handle on a gallon of milk, the lid on the container, the button on the robot coupe, a drawer handle to get a spatula, a spatula, the robot coupe container, a box of tin foil, a marker from her pocket, and the warming oven. Staff A also touched the table top surface. Without washing or sanitizing hands, Staff A obtained a new container and touched tongs and a spatula to place the second food item to be pureed into the robot coupe container, placing the container onto the robot coupe machine. Staff A touched the inside of the robot coupe container that contained food and the blade that would puree the food that went inside the container. The blade did not slide into the container correctly and Staff A continued to touch the top portion of the blade that would blend the food. Staff A did not wash hands throughout the entire pureeing process. During an interview 4/24/24 at 11:10 AM, Staff A stated washed her hands often, however could not say at what times hands should be washed, stating they are washed throughout the day. Staff A acknowledged touching objects that would come in contact with a resident's food with her hands, without washing or sanitizing her hands. During an interview 4/25/24 at 10:13 AM, the Dietary Manager (DM) stated an expectation for staff to wash hands in the kitchen while handling or preparing food, before and after putting on gloves, after handling raw food, and after handling food or touching a surface or equipment that will come in contact with food. The DM acknowledged Staff A did not wash hands after removing gloves and after touching surfaces and then touching the blade in the robot coupe prior to pureeing food. Review of the facility policy Handwashing, Specific to the Dietary Department, dated 5/16/03, documents hands will be washed with either soap and water or alcohol-based hand rubs before and after using disposable gloves, following any contact with infectious materials, and after completion of a dirty task, prior to beginning a clean task.