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	04/23/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interviews, the facility failed to ensure 1 of 1 resident (Resident #7) reviewed for pressure ulcers received the necessary care and services to promote the healing of an existing pressure ulcer and prevent the development of new ulcers. Specifically, the facility failed to clean and apply medication to Resident #7's wounds on four separate shifts, failed to document weekly pressure ulcer measurements including depth, and failed to identify the wounds as pressure ulcers on the appropriate clinical record. The facility reported a census of 42 residents.Findings include:The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: NOTE:Regardless of the staging system or wound definitions used by the facility, the facility isresponsible for completing the MDS utilizing the staging guidelines found in the RAI (Resident Assessment Instrument) Manual.Stage 1 Pressure Injury (PI): Non blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below).Stage 2 Pressure Ulcer (PU): Partial thickness skin loss with exposed dermis Partial thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar is not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions).Stage 3 Pressure Ulcer: Full thickness skin loss Full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI.Stage 4 Pressure Ulcer: Full thickness skin and tissue loss Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI. Unstageable Pressure Ulcer: Obscured full thickness skin and tissue loss Full thicknessskin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If theanatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completely debrided or free of all slough or eschar for reclassification of stage to occur.Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent nonblanchable deep red, maroon or purple discoloration Intact skin with localized area ofpersistent non blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer intothe appropriate stage. Do not use DTPI to describe vascular, traumatic, neuropathic, ordermatologic conditions.A Minimum Data Set, dated [DATE], documented diagnoses for Resident #7 included a body mass index (BMI) of 60.0 to 69.9 (extreme obesity), aphasia (language impairment disorder), and a cerebral infarction (stroke). A Brief Interview for Mental Status documented a score of 7 out of 15, which indicated severely impaired cognition. It documented that Resident #7 refused to roll left to right on the bed, lie to sit on the side of the bed, walk 50 feet with 2 turns and walk 150 feet. It documented that this resident had one Stage 2 pressure ulcer. An Office Visit to Wound Center document dated 11/21/25, documented that Resident #7 had a pressure injury of buttock stage 2. Wounds were debrided on left inner buttocks and right buttocks. The wound measurements included in this documentation included length, width and depth for both the left and right wounds. Resident #7's Non-Pressure Skin Condition Record lacked documentation from 12/11/25 through 2/25/26 on their bilateral medial thigh. The records documented the date the ulcer/s were first observed was 9/3/25. The records with the first observed date of 9/3/25 were dated 9/3/25 through 12/10/25. The records that started with an assessment done on 2/25/26 through 4/15/26 had a first observed date of 1/16/26. Resident #7's April 2026 Medication Administration Record (MAR) lacked documentation to clean wounds to bilateral medial thighs with wound cleanser. Apply Triad (wound paste) twice a day (BID) for wound care on the following dates: a. 4/7/26 for the 2 PM to 10 PM shiftb. 4/12/26 for the 6 AM to 2 PM shiftc. 4/13/26 for the 6 AM to 2 PM shiftd. 4/16/26 for the 2 PM to 10 PM shiftOn 4/22/26 at 9:36 AM, the Assistant Director of Nursing (ADON) confirmed Resident #7 did have a pressure area. The ADON stated that the wound clinic had diagnosed Resident #7 with a Stage 2 pressure ulcer. The ADON stated the facility had thought it was a moisture related wound. This ADON said that the ulcer is located on her right upper central thigh, kind of in the fold area. She stated that Resident #7 sat all day and the facility staff did encourage Resident #7 to stand and move but she often refused. On 4/23/26 at 10:33 AM, the ADON stated the facility was unable to find the missing weekly wound records. This ADON acknowledged the records the facility provided didn't identified the wounds as pressure ulcers. Most of the weekly documentation for the records didn't include depth measurements and 1 of the records had 2 wounds instead of 1 wound on each weekly assessment documentation. The ADON acknowledged they should have measured the depth, they should have identified the weekly wound records, and documented them on a Pressure Ulcer wound record and not a Non-Pressure weekly wound record. Additionally, they should have documented each wound on a separate record. She reported they thought the wound nurse was off work and the DON working at the time took over the wound nurses' duties, including the weekly measurements of pressure ulcers. The DON no longer worked at the facility and they couldn't find the records. The ADON acknowledged the facility couldn't provide several weekly Pressure Ulcer wound records. On 4/23/26 at 12:14 PM, Staff A, previous Director of Nursing (DON), explained the Skin Nurse went on vacation, she believed for 2-3 weeks, but she couldn't really remember the dates. Staff A stated she worked at the facility from December 2025 to February 2026. She added if she did the pressure ulcer wound records, they would be in the skin book or in the progress notes. She reported if the records weren't in either of the 2 places, then she (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	didn't do the assessments. Staff A said she always tried to make a skin note/progress note and a skin sheet. Staff A repeated she was the DON during that time and left the facility in March of this year and started either in July or September of last year. The Skin Management Guide revised November 2023 defined a pressure ulcer as localized damage to the skin and underlying soft tissue, usually over a bony prominence. The guide directed a licensed nurse to complete a body audit weekly or as ordered and document the findings on the electronic Treatment Administration Record (eTAR). The nurse should document new findings in the progress notes. Additionally, wound rounds need completed weekly on pressure injuries and complex wounds. The licensed nurse should document the wound location, tissue type, cause of wound, and full measurements (length, width, and depth).

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of the nursing schedules and staff interviews, the facility failed to provide a Registered Nurse (RN) in the facility for eight (8) hours per day on 4/5/26 and 4/12/26. The facility reported a census of 42 residents. Findings include:Review of the facility's nursing schedules for April 2026 lacked 8 hours of RN coverage on 4/5/26 and 4/12/26. In E-mail communication dated 4/21/26 at 12:49 PM, the facility Administrator reported the facility didn't have 8 consecutive hours of RN coverage on 4/5/26 and 4/12/26. In E-mail communication dated 4/22/26 at 1:08 PM, the Nurse Consultant explained the facility didn't have a policy for RN coverage as they just follow the regulation. During an interview on 4/22/26 at 2:15 PM the Administrator acknowledged the facility didn't have 8 hours of continuous RN coverage on 4/5/26 and 4/12/26. The Administrator added they had a plan in place moving forward for coverage.