STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366190	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Manor	51999 Guirino Drive St Clairsville, OH 43950

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review the facility failed to ensure food that was expired and noted with mold. This affected all 52 residents in the facility. The facility census was 52.Findings include:Observations on 02/23/26 between 8:40 A.M. and 8:57 A.M. during the initial tour of the facility kitchen revealed an open cardboard box of on the bottom shelf in the pantry area with large Idaho potatoes. Several potatoes appeared to have a dusty fuzzy brownish blue film on them and some of the potatoes were cut in half with the dusty fuzzy brownish blue film on the open side of the potato. Further observation revealed a gallon of chocolate milk about one quarter full with an expiration date of 02/22/26 in the walk-in refrigerator. Interview on 02/23/26 at 8:58 A.M. with the dietary manager (DM) #202 revealed confirmation that the potatoes had some type of brownish blue fuzzy layer on them and removed the potatoes and placed them in the trash. DM #202 further confirmed the chocolate milk had an expiration date of 02/22/26 and removed the milk from the refrigerator and discarded it.Review of the facility's Food Receiving and Storage policy (undated) revealed refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded.

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure residents or resident representatives knew in advance what charges a facility may impose against a resident's personal funds. This affected four residents (#8, #5, #22, #35) of five residents reviewed for personal funds. The facility census was 52. Findings include:1.Record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including congestive heart failure, insomnia, diabetes, and transient ischemic attack.Review of Resident #8's quarterly banking statement revealed a charge in the amount of $7.05 titled bank service charge dated 01/31/26.2. Record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including cognitive communication deficit, major depressive disorder, and paraplegia. Review of Resident #5's banking statement revealed a charge in the amount of $5.47 titled bank service charge dated 01/31/26. 3. Review of Resident #22's record revealed the resident was admitted on [DATE] with diagnoses including dementia, anxiety, Alzheimer's, and major depressive disorder.Review of Resident #22's banking statement revealed a charge in the amount of $1.23 titled bank service charge dated 01/31/26.Review of the Personal Funds Disposition Form revealed a statement reading the resident and/or resident representative authorize the facility to manage their personal funds while they [the resident] reside within the facility. This means the facility has the right to make deposits in my [the residents] personal account for me [the resident], and to make expenditures in my behalf for personal expenses that I may incur while staying in said facility. The form was dated 03/17/25 and witnessed by a contracted employee of the facility Certified Occupational Therapy Assistant (COTA) #255.4. Review of Resident #35's record revealed the resident was admitted on [DATE] with diagnoses including restlessness and agitation, wandering, diabetes, anxiety, Alzheimer's, and disorientation. Review of Resident #35's banking statement revealed a charge in the amount of $0.12 titled bank service charge dated 01/31/26. Interview with business office personnel #501 on 02/26/26 at 9:25 A.M. confirmed there is a banking service fee charged to each resident. This charge comes from the bank itself, not the facility, so she does not know much about it, it is a different fee for each resident and can vary because it depends on how much money is in the resident's account that month [the fee is a monthly charge]. Business office personnel #501 confirmed they were unaware if residents have been notified about the banking service fee. PNC bank handles the residents' trusts and funds. Business office personnel #501 confirmed COTA #255 who witnessed authorization forms for Resident #50 and Resident #22 is a contracted facility staff member.Review of the facility admissions packet, admission agreement cheat sheet notes, and facility rules, regulations, policies and procedure guides revealed no evidence of residents or their representatives being aware of the service fee charged monthly by PNC bank for residents to have their funds managed by the facility. Review of the personal funds disposition form statement revealed the form must be witnessed by a non staff member, examples or another family member, or another resident.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, hospital record review, staff interviews, review of literature from the American Heart Association, and policy review, the facility failed to timely assess and monitor the cardiopulmonary status, including weights. This affected one resident (#25) of two residents reviewed for hospitalizations. The facility census was 52.Findings include: Record review revealed Resident #25 was admitted to the facility on [DATE] with a primary diagnosis of congestive heart failure. Resident #25's other diagnoses included respiratory failure, heart disease, anemia (low blood count), chronic kidney disease, diabetes, high blood pressure, and continuous oxygen use. Review of the nursing assessment completed on 01/05/26 upon admission to the facility revealed Resident #25 was alert and oriented to person, place, and time, lung sounds were clear, vital signs were stable, oxygen at two liters per minute, and 3+pitting edema (significant swelling on a 0-4 scale with 0 being none and 4 being the most severe) to bilateral arms and lower legs.The resident refused to be weighed on this date (01/05/26). Review of resident's hospital paperwork prior to her admission to the facility revealed the resident weighed 172 pounds on 01/02/26.Review of the physician orders for Resident #25 revealed an order dated 01/05/26 for facility staff to obtain weights daily for three days, then weekly for four weeks, then monthly.Review of Resident #25 care plan dated 01/05/26 revealed interventions for congestive heart failure to include weight monitoring as ordered by physician and as needed, observe and report signs and symptoms of congestive heart failure including but not limited to shortness of breath upon exertion, weight gain unrelated to intake, and orthopnea (difficulty breathing when lying flat).Review of the initial comprehensive minimum data set (MDS) assessment completed on 01/13/26 revealed Resident #25 had a brief interview for mental status score of 7/15 indicating severe cognitive impairment. Further review of the MDS assessment revealed Resident #25 was dependent on staff for personal care including dressing, bathing, and transferring out of bed. Resident #25 also required use of a wheelchair navigated by staff for mobility. The resident was incontinent of urine.Review of the medical record revealed an initial facility history and physical note completed on 01/08/26 authored by nurse practitioner (NP) #500 stating Resident #25 was found to have wheezes (an abnormal lung sound caused by narrowed or obstructed airways) and rales (abnormal lung sounds caused by mucus, fluid, or collapsed airways) noted during examination with continued severe swelling to lower legs. NP #500 prescribed Lasix 20 milligrams (mg) twice a day to start 01/09/26 (a diuretic medication used to treat fluid retention caused by conditions including congestive heart failure, and kidney disorders, and recommendations include daily monitoring of weights).Review of Resident #25's medication administration record (MAR) revealed the resident received Lasix as ordered by NP #500. However, there was no evidence that the resident was monitored or assessed for effectiveness of the medication.Another progress note dated 01/06/26 revealed Resident #25 refused to be weighed at this time and requested to be weighed after the X Ray of her right leg was done on this date. There was no weight recorded for 01/06/26 and no evidence the resident refused on this date. Further review of the medical record revealed on 01/07/26 Resident #25 weighed 177.6 pounds. There were no other weights recorded for Resident #25 after the weight obtained on 01/07/26. There was no evidence the resident had refused to be weighed. Further review of Resident #25's medical record revealed the NP #500 gave new orders on 01/08/26 for labs to be obtained on 01/09/26 for a basic metabolic panel (BMP) and complete blood count (CBC) which were obtained. The lab results revealed an elevated kidney function with a blood urea nitrogen (BUN) level of 69 mg/dL (normal BUN kidney function is identified as 6-24 mg/dL) and creatinine level of 1.12 (normal creatinine level is 0.6 to 1 3 mg/dL) and a hemoglobin (Hg) level of 9.0 (normal hemoglobin level is 12-15.5 g/dL)) and white blood cell count (WBC) of 17.2 (normal WBC ranges from 4-11). Further record revealed NP #500 was notified of lab results on 01/09/26 and responded that Resident #25 had chronic kidney disease stage 3. There were no new treatment orders.On 01/09/26 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NP #500 gave an additional order to repeat labs for BMP and CBC on Monday 01/12/26. The labs were obtained on 01/12/26 and revealed continued elevation of the kidney function. The resident's BUN was 62 and creatinine was 1.09. The resident's WBC level had improved to 12.2. The resident's hemoglobin level had worsened and was now 8.0. The NP #500 was notified on 01/12/26 of the labs results and orders were given to have Resident #25 drink more water. Review of the medical record for Resident #25 revealed a pulse oximeter reading (device used to determine the saturation of oxygen molecules attached to the red blood cells with normal levels being 92-100%) was being checked twice a day with each shift from 01/05/26 through 01/13/26 with readings between 95-99% on 2-3 liters per minute via nasal canula.Review of the medical record for Resident #25 revealed skilled nursing assessments completed twice (each shift) a day starting on 01/05/26 through 01/13/26. Further review of each nursing assessment revealed documentation of cardiopulmonary assessment including observation of edema, lung sounds, breathing status, existence of oxygen and nebulizer use. All assessments completed for Resident #25 revealed no abnormal lung sounds, that Resident #25 was short of breath with exertion, had 3+ pitting edema to bilateral lower extremities and oxygen use at 3 liters/min via nasal canula and received nebulizer (breathing) treatments[LW1.1].Continued review of Resident #25 medical record revealed on 01/12/26 at 10:51 A.M. a complete nursing assessment revealed no change in lung sounds; however the resident had a change and now was short of breath while lying flat so the head of the resident's bed was elevated. Review of Resident #25 nursing progress note dated 01/12/26 at 12:26 P.M. revealed Resident #25 was short of breath while lying flat and a new intervention was added to keep the head of bed elevated at all times. Further review of Resident #25 medical record revealed no documentation of a medical provider/physician being notified of the resident's new onset of orthopnea.There was no evidence Resident #25's medical provider was notified of the resident's change in respiratory status and new onset of becoming short of breath while lying down (orthopnea).Further review of Resident #25 progress notes revealed a note dated 01/13/26 at 4:40 P.M. stating Resident #25 was found to have blisters on the skin of lower legs that were not present during her AM shower that day. The resident was noted with shortness of breath. The note further revealed vital signs being obtained as blood pressure of 145/70, heart rate of 89 beats per min, respiratory rate of 24, and pulse oximeter [NAME] of 98% on 3 liters of oxygen, and continued 3+ edema to bilateral upper and lower extremities. The progress note further revealed notification to the NP #500 of the resident's condition with new orders to send Resident #25 to the emergency room.Review of Resident #25 hospital records revealed a hospitalization from 01/13/26 to 01/23/26, totaling a ten-day hospital stay. Resident #25 was admitted to the hospital with a primary diagnosis of acute exacerbation of congestive heart failure with hypoxia (lack of oxygen). Other hospital admission diagnoses included pneumonia, obstructive uropathy (blockage in urinary system to prevent flow of urine) and hydronephrosis (water on the kidney).Observation and interview on 02/23/26 at 9:25 A.M. revealed Resident #25 resting in bed with head of bed elevated and wearing continuous oxygen at 2.5 liters via nasal canula. Resident #25 was observed to have a non-productive cough. Resident #25 reported she was hospitalized last month but could not provide details of events of hospitalization. Resident #25 further stated she thinks she was in the hospital for pneumonia and is uncertain if she was still on antibiotics. Interview on 02/25/26 at 11:10 A.M. with registered nurse (RN) #110 revealed the facility does not have any congestive Heart failure protocols for monitoring weights or symptoms. RN #110 reported that the nurses only obtain daily weights on residents if the provider/physician would order daily weights, otherwise the facility follows its weight protocol for all admissions of daily weights for three days, then weekly weights for four weeks, then monthly weights. RN #110 confirmed that the nurses can ask or recommend to the providers/physicians to obtain daily weights. RN #110 further reported that the nursing staff would monitor for signs and symptoms of congestive heart failure including increased shortness of breath, abnormal lung sounds, decreased oxygen levels, and increased swelling of arms and legs and notify the physician or provider of any changes to the residents status. RN #110 also confirmed from her nursing knowledge that (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents with heart failure should be weighed daily and if the resident would gain 3-5 pounds in 24 hours it should be reported to the provider/physician. Interview on 02/25/26 at 12:20 P.M. with the Director of Nursing (DON) revealed that the facility does not report refusal or inability to obtain weights of residents to the providers/physicians unless it is persistent and affecting care of the residents. The DON further confirmed there was only one weight recorded for Resident #25 prior to hospitalization and no documentation of provider/physician notification of weights not being obtained. There was no documentation of recommendations by nursing staff for monitoring of daily weights. The DON agreed that the weights for Resident #25 should have been monitored more closely due to diagnosis of heart failure. According to the American Heart Association (AHA) website (www.heart.org/en/health-topics/heart-failure/living-with-heart-failure-and-managing-advanced-hf/physical-cha symptoms to monitor for congestive heart failure include: Rapid weight gain. The AHA further instructs individuals with heart failure to Ask your health care professional about the amount of weight gain you should report to them. It's important to weigh yourself every day, in the morning before breakfast and after urinating. Weigh yourself with the same type of clothes on, without shoes, on the same scale and in the same location. The AHA further indicates symptoms of heart failure can include increased swelling of legs and need for more pillows at night to prevent shortness of breath.Review of the facility policy titled Notification of Resident Change, with a review date 01/26 revealed a physician will immediately be notified regarding a change in the resident's condition related to a significant change in the resident's physical, mental, or psychosocial status, or a need to alter treatment significantly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, policy review, and record review, the facility failed to follow Enhanced Barrier Precautions (EBP) to reduce the transmission of multidrug-resistant organisms in high contact resident care activities. This affected one resident (#20) of three residents reviewed for pressure ulcers. The facility census was 52.Findings include:Review of the medical record for Resident #20 revealed an admission date for 02/13/26. Diagnoses included type 2 diabetes mellitus, urinary tract infection, muscle weakness, overactive bladder, allergic rhinitis, hyperlipidemia, hypertension, atherosclerotic heart disease, need for assistance for personal care, difficulty in walking, lack of coordination, constipation, history of falling, pressure ulcer of sacral region, unstageable.Review of the medical record for Resident #20 revealed a Minimum Data Set (MDS) version 3.0, dated 02/20/26. The Brief Interview for Mental Status (BIMS)scored a 15 on a 0-10 scale. A score of 15 indicated intact cognitive function. The MDS further indicated the resident used a walker. There was no evidence of wheelchair use. She required set up and clean-up assistance with eating, was dependent with oral care, needed substantial to maximal assistance with toileting, dependent with showering and footwear, and needed substantial assistance with all other activities of daily living (ADL).Review of the medical record for Resident #20 revealed a initial care plan with a focus of care for the potential for pressure ulcer development. Goals of care included not developing any pressure ulcers. Interventions included consulting dietary, using enablers for turning and positioning, and a low air loss mattress which should be adjusted based on resident comfort. The resident should have a weekly skin evaluation.On 02/25/26 at 9:15 A.M., an observation of Resident #20's wound care revealed the resident had a stage III pressure ulcer (PU) to her sacrum. Wound care was provided by Registered Nurse (RN) #110. No infection control issues were noted during wound care.On 02/25/26 at 9:15 A.M., an observation of Room C1, Resident #20's room, failed to reveal any signage for Enhanced Barrier Precautions (EBP). This was confirmed by RN #110 at the time of the observation.On 02/25/26 at 9:25 A.M., an interview with RN #110 revealed the facility only used EBP when wounds were present for over a month or more. EBP was also used for residents who had foley catheters or intravenous lines. The facility did not use EBP when a pressure ulcer was new.Review of the facility Enhanced Barrier Precautions (EBP) policy dated 03/27/24, revealed an EBP sign will be placed on the resident's door and PPE will be inside of the resident's room near the door. EBPs are indicated for residents with any of the following regardless of where they reside in the facility: wounds and/or indwelling medical devices. Wounds include chronic wounds such as pressure ulcers. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: wound care.