STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366443	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belpre Landing Nursing and Rehabilitation	1915 Hill Street Belpre, OH 45714

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 observation, record review, hospital record review and interview, the facility failed to ensure Resident #2, with a known history of hypothermia, was comprehensively monitored for a change in condition to ensure timely notification to the resident's medical provider to prevent a delay in treatment. This affected one resident (#2) of three sampled residents reviewed for quality of care. The facility census was 49.Actual Harm occurred on 01/17/26 when Resident #2 was noted to exhibit decreased consciousness and was transported to the hospital for evaluation where she was admitted with hypothermia (body temperature of 91 degrees F) and multiple infections requiring treatment in the intensive care unit and antibiotic therapy. Resident #2, who was dependent on a ventilator for breathing, dependent on staff for care, had diagnosis of multiple sclerosis and had been re-admitted to the facility (on 12/24/25) from the hospital after being treated for hypothermia (with a temperature of 93 degrees Fahrenheit (F)) related to multiple sclerosis and infection. Upon re-admission, the facility failed to have a comprehensive system in place for monitoring for signs and symptoms of hypothermia. Resident #2 had low body temperature readings on 01/14/26, no temperature assessed on 01/15/26 and a low temperature on 01/16/26 with no physician notification or evidence of increased monitoring or assessment of the resident. The resident was subsequently transferred to the hospital and treated for hypothermia.Findings include:Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including anemia, dependence on ventilator, multiple sclerosis, and functional quadriplegia. According to the National Institute of Neurological Disorders and Stroke, multiple sclerosis (MS) is a chronic neurological disorder. It's an autoimmune disorder, meaning that in MS, the immune system, which normally protects us from viruses, bacteria, and other threats; mistakenly attack healthy cells. Review of a care plan dated 04/02/25 revealed Resident #2 had an alteration in respiratory functions related to respiratory failure, tracheostomy and ventilator, history of aspiration pneumonia and mucus plugging or bronchus. Goals included to be free from respiratory distress through the review date. Interventions included to assess lung sounds per orders and nursing judgement, report abnormal breath sounds to provider, AVAP per physician order, change tracheostomy tube every 30 to 45 days and as needed (trach size six Shiley), CPT as ordered, evaluate shortness of breath for pain and discomfort when breathing and administer medications as ordered to relieve, instruct resident in pursed lip breathing technique and coughing and deep breathing techniques, maintain head of bed elevated to prevent shortness of breath, monitor vital signs as ordered and report any abnormalities to provider, nursing to monitor resident and assess for effectiveness of respiratory treatment: vitals, lung sounds, mental status, skin color, and report abnormalities to provider, nursing to assure set up of all required equipment and clean up after, provide oxygen as ordered, and provide respiratory treatment as ordered. Review of a care plan dated 04/02/25 revealed Resident #2 was at risk for infection related to nursing home stay, tracheostomy status, surgical wound, suprapubic catheter, gastrostomy (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	(g-tube) and history of infections. The goal was to remain free of signs and symptoms of infection through the review date. Interventions included assessing signs and symptoms of infection and report to provider: redness, swelling, increased pain, purulent drainage, elevated temperature, change in color of secretions, cough, congestion, abnormal lung sounds, diarrhea, and vomiting. Review of a care plan dated 04/02/25 revealed Resident #2 had an alteration in respiratory function and required a tracheostomy and ventilator. Goals included oxygen level to be kept at desired levels set per provider through the review date. Interventions included to administer oxygen as ordered, aerosol treatments as ordered, change aerosol nebulizer set-up as ordered, change closed suction catheter system as ordered, change heated moisture exchange as ordered, change size six Shiley tracheostomy inner cannula as ordered, change trach ties as ordered, change ventilator circuit as ordered, cleanse tracheostomy site as ordered, ensure ventilator was on proper settings per orders: AC/VC via tracheostomy continuous, pressure control (PC) 22, respiratory rate (RR) 20, Inspiratory time 1.2, Positive End- Expiratory Pressure (PEEP) 6, fraction of inspired oxygen (FIO2) 32%, ventilator checks every four hours, medications as ordered, monitor lung sounds as ordered, monitor oxygen levels as ordered; and observe for signs and symptoms of dyspnea: labored respiration, low oxygen, use of accessory muscles, cyanosis, changes in mental status, and tachypnea, provide inhalers as ordered, respiratory therapist to change tracheostomy tube every 35 to 40 days and as needed, and suction trach per orders. Review of a care plan dated 10/22/25 revealed Resident #2 had an alteration in musculoskeletal status related to muscle weakness, multiple sclerosis, and functional quadriplegia. The goal was to remain free from complications related to musculoskeletal status through the review date. Interviews included to administer medications per physician orders and monitor for effectiveness/side effects, anticipate and meet needs, ensure call light was within reach and respond promptly to all requests for assistance, assist with activities of daily living (ADLs) and care as needed, educate resident and family on joint conversation techniques as indicated, monitor and document for fall risk, educate resident and care givers on safety measures to reduce risk; pain assessment per facility policy, skin assessment per facility policy, and therapy to evaluate and treat as indicated. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2's cognition was intact and she was able to make her needs known. Review of a nursing note dated 12/04/25 at 2:11 P.M. authored by Licensed Practical Nurse (LPN) #164 revealed Resident #2 was having complaints of feeling really hot, vitals were taken and her blood pressure was 168/84 (hypertensive), heart rate was 53 beats per minute (bradycardic), and temperature was 93 degrees Fahrenheit (F) (hypothermic). (Medical) Provider was notified and gave orders to transfer the resident to the hospital. 911 was contacted and resident's family updated. Report was called to the local hospital. Hypothermia is a condition that occurs when core body temperature drops below 95 degrees Fahrenheit (F). It is a medical emergency. In hypothermia, the body loses heat faster than it can produce heat, causing a dangerously low body temperature. Normal/regular body temperature is around 98.6 degrees Fahrenheit. When body temperature drops, the heart, nervous system and other organs can't work as well as they usually do. Left untreated, hypothermia can cause the heart and respiratory system to fail and eventually can lead to death Review of a nursing note dated 12/24/25 at 12:38 P.M. authored by LPN #108 revealed Resident #2 was re-admitted to the facility (from the hospital stay that started 12/04/25) via stretcher, orders were verified and assessments were completed. Vitals were obtained and Resident #2 was alert and able to communicate needs. Record review revealed on 01/14/26 at 8:19 A.M. Resident #2 temperature was documented to be 98 F. Additionally, at 4:38 P.M., she had a temperature of 97.3 F which the (electronic) system triggered as a low exceeding 97.8 F. There was no corresponding nursing note. There was no evidence the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	resident's condition was thoroughly assessed at this time. Record review revealed no evidence the resident's physician was notified of the low temperature reading, no evidence a comprehensive assessment of the resident was completed, and no evidence the resident's temperature was re-checked. Review of the temperature log revealed no temperature was taken for Resident #2 on 01/15/26. There was no evidence that the resident's condition was thoroughly assessed and monitored on this date. On 01/16/26 at 4:35 P.M. Resident #2's temperature was noted to be 96.4 F which the (electronic) system triggered as a low exceeding 97.8 F. There was no corresponding nursing note. There was no evidence that the resident's condition was thoroughly assessed at this time. Record review revealed no evidence the resident's physician was notified of the low temperature reading, no evidence a comprehensive assessment of the resident was completed, and no evidence the resident's temperature was re-checked. On 01/17/26 at 1:16 P.M. Resident #2's temperature was 95.7 F which the (electronic) system triggered as a low exceeding 97.8 F. A follow-up nursing note dated 01/17/26 at 1:46 P.M. by Registered Nurse (RN) #140 revealed Resident #2 was showing signs of increased confusion and repeating herself. The resident's temperature was documented to be 85.7 F, and verbal orders were received to send the resident to the emergency room for evaluation. Resident's family was notified and the resident was transported to a local hospital. Review of a nursing note dated 01/17/26 at 3:46 P.M. by Registered Nurse (RN) #140 revealed the hospital updated the facility and stated Resident #2 was being admitted and was in a warmer as her temperature was registering at 91 F. Review of a hospital note dated 01/17/26 revealed Resident #2 was admitted to the hospital with ventilator associated pneumonia ([NAME]), septic shock, and a complicated urinary tract infection with EBL producing E. Coli which were treated with antibiotics, Vancomycin (glycopeptide antibiotic used for serious Gram-positive bacterial infections) and Merrem (broad spectrum antibiotic). Additionally, Resident #2 had hypothermia with a temperature of 91. F on arrival to the emergency department which was resolved with a [NAME] (a clinical, forced-air warming device that uses a specialized blanket and heater unit to maintain a patient's normal body temperature (normothermia) during pre-operative, intraoperative, and post-operative, stages) and treatment of infection. The hospital note included hypothermia was likely in the setting of acute infection and baseline of advanced multiple sclerosis. Resident #2 returned to the facility on [DATE] after receiving treatment in the intensive care unit including antibiotic therapy. Interview on 01/22/26 at 4:32 A.M. with Respiratory Therapist (RT) #172 revealed Resident #2 had been admitted to the hospital twice in the last two months for hypothermia. RT #172 stated she learned dry lips are a sign of hypothermia. RT #172 stated Resident #2's room would be cold, but she would decline for the heat to be turned on because she felt comfortable. Interview on 01/22/26 at 12:55 P.M. with Nurse Practitioner (NP) #305 revealed at this time, she was not aware of increased monitoring for Resident #2 related to episodes of hypothermia. NP #305 stated she had not spoken with the medical director yet to see if there was anything that could be done since the hypothermia was related to multiple sclerosis but stated perhaps the staff could check the resident's vital signs more frequently, maybe once a shift. Interview on 01/28/26 at 1:26 P.M. with Certified Nursing Assistant (CNA) #158 revealed when she would provide care for Resident #2, she would notice her skin was very cold but Resident #2 always stated she was fine. CNA #158 stated there was no increased monitoring being completed officially, but stated since the two instances of hypothermia, she had been checking in more frequently on Resident #2. CNA #158 was not sure what the symptoms of hypothermia were but stated she checked vital signs and would let the nurse know if something arises. During the interview, CNA #158 identified resident vital signs are normally taken once every shift. Interview on 01/28/26 at 4:20 P.M. with Director of Nursing (DON) confirmed Resident #2 had hypothermia related to infections and (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	multiple sclerosis. The DON confirmed the care plan said to monitor resident for elevated temperature despite the fact that her temperature drops once she has an infection due to multiple sclerosis. The DON confirmed their (electronic) system triggered multiple low temperatures for Resident #2 (as noted on the dates above) with no evidence of staff follow-up (comprehensive assessments) or notification to the physician documented. The DON stated there was increased monitoring of Resident #2's room temperature since she was re-admitted to the facility on [DATE] but could not provide evidence of increased monitoring of Resident #2's body temperature. Per the DON, resident vital signs are typically obtained once per shift. On 01/28/26 at 4:35 P.M. Resident #2 was observed in her room. The room felt cool, but not cold. During the observation, the resident did not voice any current concerns related to her care by staff. The resident stated she was comfortable at this time and did not feel too cold. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2702282.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interview, and policy review, the facility failed to ensure respiratory care was completed as ordered. This affected two residents (#1 and #2) of two residents reviewed for respiratory care. The facility census was 49. Findings include: 1.Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including sepsis, pneumonia, and acute and chronic respiratory failure with hypoxia. Review of a care plan dated 01/08/26 revealed Resident #1 had an alteration in respiratory function related to respiratory failure with hypoxia and hypercapnia, pneumonia, dependence on a respiratory and tracheostomy. Goals included to be free of respiratory distress through the review date, show adequate oxygen perfusion through review date, and lungs will be clear to auscultation and spO2 will be above 90% through the review date. Interventions included but were not limited to assess lung sounds per orders and nursing judgment, report abnormal breath sounds to physician; evaluate shortness of breath for pain and discomfort when breathing and administer medications as ordered to relive; maintain head of bed elevated to prevent shortness of breath; medications for secretions; monitor vital signs as per orders and report any abnormalities to the provider; nursing to monitor resident and assess for effectiveness of respiratory treatment, vital signs, lung sounds, mental status, skin color, and will report abnormalities to provider, nursing to assure set up of all required equipment and clean up after; provide oxygen as ordered; and provide respiratory treatment as ordered. Review of a care plan dated 01/09/26 revealed Resident #1 had an alteration in respiratory function and required oxygen use, tracheostomy, and ventilator. Goals included oxygen levels will be kept at desired levels set per physician through review dated. Interventions included but were not limited to administer oxygen as ordered; ensure ventilator is set on proper settings (PSV via tracheostomy: QHS 10/5, FIO230%); monitor lung sounds as ordered; monitor oxygen levels as ordered; observe for signs and symptoms of dyspnea: low oxygen, use of accessory muscles, cyanosis, changes in mental status, tachypnea; PMV as tolerated; size eight Shiley tracheostomy inner cannula; suction trach per orders; and trach care as needed. Review of orders revealed an order dated 01/12/26 to change Resident #1's heat moisture exchange (HME) daily and as needed. Review of a treatment administration record (TAR) for January 2026 revealed Resident #1's HME was changed on 01/12/26. Review of a respiratory progress note dated 01/15/26 at 6:27 P.M. by Respiratory Therapist (RT) #172 revealed Resident #1 was on four liters with a trach mask, trach and oral care completed, suction as needed, the inner cannula was changed, HME was changed, CPO was in place, a respiratory assessment was completed at this time, ventilator was on standby at bedside, all ventilator cords were plugged in and connected to the correct electrical outlet, Resident #1's call light was in reach, the resident had a full tank of oxygen with ambu bag at bedside along with extra tracheostomy (trach) supplies. Review of a treatment administration record (TAR) for January 2026 revealed Resident #1's HME was changed on 01/15/26. Review of a respiratory progress note dated 01/21/26 at 10:10 P.M. by RT #172 revealed Resident (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1's trach care and oral care were completed, he was suctioned as needed, and the HME and inner cannula were changed. Resident #1's call light was within reach and per his request staff awaited nurse to administer melatonin before placing him on the ventilator. Review of a treatment administration record (TAR) for January 2026 revealed Resident #1's HME was changed on 01/21/26. There was no additional evidence of Resident #1's HME being changed daily as ordered. Review of a minimum data set (MDS) completed on 01/26/26 revealed Resident #1's cognition remained intact. Interview on 01/22/26 at 9:49 A.M. with Nurse Practitioner (NP) #305 revealed she was not familiar with what an HME was but she researched it and found an HME humidifies air so the lungs are not getting dry. Concerns related to not changing the HME include pneumonia related to bacteria or aspiration due to increased airway resistance, mucus plugging, hypothermia, pneumonia and potential respiratory distress. NP #305 confirmed Resident #1's TAR only had as needed HME replacement listed and was completed on 01/12/26, 01/15/26, and 01/21/26 and no evidence of the HME being changed daily as ordered. NP #305 stated she was unsure where the orders come from since she does not give orders for tracheostomy or ventilator care. Interview with Director of Nursing (DON) on 01/22/26 at 12:58 P.M. revealed the order for Resident #1's HME to be changed stated daily but was only entered as needed. The DON stated he spoke with an RT who stated changing the HME does not need to be a separate order because it is a standard part of ventilator care and since the ventilator care was being documented daily, there was no concern. Interview on 01/28/26 at 7:08 A.M. with RT #160 revealed the HME is for humidification and it is called the heated moisture exchange and they keep the lungs moist. RT #160 stated HMEs are good for 24 hours and get changed every time care is completed. RT #160 stated the HME has to be its own separate order because if you provide ventilator care and everything is a mess, it doesn't mean the HME is a mess. RT #160 stated the HME is changed daily and as needed when soiled. RT #160 stated Resident #1's HME order was a clerical error and was entered incorrectly, but he was confident the care was still being completed daily despite the lack of documentation because he had gone in and checked dates on the HMEs with no concerns. RT #160 again stated the HME is it's own order and not grouped in with ventilator care orders. 2. Medical record review revealed Resident #2 was admitted on [DATE] with diagnoses including multiple sclerosis, chronic respiratory failure with hypoxia, tracheostomy and dependence on respirator/ventilator, history of ventilator associated pneumonia and sepsis. Review of the care plan: Alteration in respiratory function and requires tracheostomy, ventilator dated 04/02/25 revealed interventions included to change size 6 disposable tracheostomy inner cannula as ordered and cleanse tracheostomy site as ordered. Review of the electronic Physician Orders dated January 2026 revealed to cleanse the tracheostomy site with sterile water, pat dry and apply drain sponge. Change every shift and as needed (PRN), and change size 6 Shiley tracheostomy inner cannula every shift and PRN. On 01/28/26 between 8:20 A.M. to 8:39 A.M., observation of Resident #2's tracheostomy inner cannula (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and site care revealed the following: Respiratory Therapist (RT) #160 applied a protective gown, performed hand hygiene and donned non-sterile gloves. RT #160 was not observed to be wearing a mask. Observation of the bedside table revealed personal items were located on one-side of the table and treatment supplies were placed on the other side. There was no barrier or sterile field used for the tracheostomy supplies. RT #160 opened the tracheostomy care kit, split drain gauze, hydrogen peroxide and sterile saline. RT #160 removed the blue sterile gloves from the tracheostomy care kit and stated the sterile gloves were a medium size and did not fit his hands. RT #160 was observed throwing the sterile gloves in the trash. RT #160 removed the sterile items from the tracheostomy kit with non-sterile gloves, poured sterile water and hydrogen peroxide into the kit cleaning tray and inserted a split 4x4 gauze into the solution. RT #160 folded the gauze in half and cleaned around the lower aspect of Resident #2's tracheostomy stoma and disposed of the gauze. RT #160 grasped a second split 4x4 gauze with the same non-sterile gloves, inserted the gauze into the solution, cleaned around the upper aspect of Resident #2's tracheostomy stoma and disposed of the gauze. RT #160 removed his non-sterile gloves and disposed of them into the trash. RT #160 washed his hands at the sink, donned non-sterile gloves, returned to the bedside and placed a split gauze around the resident's tracheostomy stoma. RT #160 removed his gloves, washed his hands at the sink and donned non-sterile gloves. RT #160 grasped a sterile disposable tracheostomy inner cannula with his non-sterile gloved hand, disconnected the ventilator tubing, removed the used inner cannula from the resident's tracheostomy and inserted a new disposable inner cannula. RT #160 disposed of the used inner cannula, reattached the ventilator tubing to the tracheostomy, removed his gloves and isolation gown, and washed his hands at the sink. RT #160 stated the procedure was completed using a non-sterile procedure. On 01/28/26 at 3:34 P.M., interview with the Director of Nursing verified tracheostomy care was to be completed using sterile technique including sterile gloves, use of a barrier for supplies and appropriate personal protective equipment including a mask should be used. On 01/28/26 at 3:45 P.M., interview with RT #160 verified he did not use a barrier or wear a mask during tracheostomy care but stated he was arms length away from the resident during the procedure. RT #160 verified he wore non-sterile gloves because the sterile gloves in the tracheostomy kit were a medium size and he required a large sized glove. RT #160 verified the facility did have sterile gloves available to use but the procedure did not require a sterile procedure. RT #160 verified the facility policy was to use sterile techniques at all times; however, RT #160 stated the policy was wrong. Review of the undated policy: Tracheostomy and Tracheostomy Tube Care revealed a tracheostomy was a surgical opening in the trachea. Meticulous tracheostomy and trach tube care was mandatory to prevent complications. Since the tracheostomy was essentially an open wound and the normal protective mechanism in the upper airway are bypassed, the most hazardous complication was infection and prevention of infection was the primary goal of proper tracheostomy care techniques. To minimize the potential hazard of tracheostomy wound (stoma) infection the area was to be cleansed regularly using sterile technique at all times. To minimize the potential hazard of acute bronchopulmonary infection due to contamination of the artificial airway the inner cannula was to be cleaned regularly using sterile technique at all times. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2702282.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of staff schedules, review of the National Library of Medicine literature, and interviews, the facility failed to ensure sufficient registered nurses or respiratory therapists were available at the facility to care for residents with ventilators. This affected two (#1 and #2) of two residents with ventilators. The facility census was 49. Findings include:1.Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including sepsis, pneumonia, and acute and chronic respiratory failure with hypoxia. Review of an order dated 01/08/26 revealed Resident #1 required a ventilator check every four hours and as needed. Review of a care plan dated 01/08/26 revealed resident #1 had an alteration in respiratory function related to respiratory failure with hypoxia and hypercapnia, pneumonia, dependence on a respiratory and tracheostomy. Goals included to be free of respiratory distress through the review date, show adequate oxygen perfusion through review date, and lungs will be clear to auscultation and spO2 will be above 90% through the review date. Interventions included but were not limited to assess lung sounds per orders and nursing judgment, report abnormal breath sounds to physician; evaluate shortness of breath for pain and discomfort when breathing and administer medications as ordered to relive; maintain head of bed elevated to prevent shortness of breath; medications for secretions; monitor vital signs as per orders and report any abnormalities to the provider; nursing to monitor resident and assess for effectiveness of respiratory treatment, vital signs, lung sounds, mental status, skin color, and will report abnormalities to provider, nursing to assure set up of all required equipment and clean up after; provide oxygen as ordered; and provide respiratory treatment as ordered. Review of orders dated 01/09/26 revealed Resident #1 required tracheostomy care: cleanse site with sterile water, pat dry, apply drain sponge, and change every shift and as needed; and change size 8 Shiley tracheostomy inner cannula every shift and as needed. Additionally, an order dated 01/09/26 revealed Resident #1 required suctioning via trach as needed and saline may be used if needed. Review of a care plan dated 01/09/26 revealed Resident #1 had an alteration in respiratory function and required oxygen use, tracheostomy, and ventilator. Goals included oxygen levels will be kept at desired levels set per physician through review dated. Interventions included but were not limited to administer oxygen as ordered; ensure ventilator is set on proper settings (PSV via tracheostomy: QHS 10/5, FIO230%); monitor lung sounds as ordered; monitor oxygen levels as ordered; observe for signs and symptoms of dyspnea: low oxygen, use of accessory muscles, cyanosis, changes in mental status, tachypnea; PMV as tolerated; size eight Shiley tracheostomy inner cannula; suction trach per orders; and trach care as needed. Review of orders revealed an order dated 01/12/26 to change Resident #1's heat moisture exchange (HME) daily and as needed. 2.Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including anemia, dependence on ventilator, and functional quadriplegia. Review of a care plan dated 04/02/25 revealed Resident #2 had an alteration in respiratory functions related to respiratory failure, tracheostomy and ventilator, history of aspiration pneumonia and mucus plugging or bronchus. Goals included to be free from respiratory distress through the review date. Interventions included but were not limited to assess lung sounds per orders and nursing judgement, report abnormal breath sounds to provider; AVAP per physician ordered; change tracheostomy tube every 30 to 45 days and as needed, trach size six Shiley; CPT as ordered; evaluate shortness of breath for pain and discomfort when breathing and administer medications as ordered to relieve; instruct resident in pursed lip breathing technique and coughing and deep breathing techniques; maintain head of bed elevated to prevent shortness of breath; monitor vital signs as ordered and (continued on next page)

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	366443	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belpre Landing Nursing and Rehabilitation	1915 Hill Street Belpre, OH 45714

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report any abnormalities to provider; nursing to monitor resident and assess for effectiveness of respiratory treatment: vitals, lung sounds, mental status, skin color, and report abnormalities to provider, nursing to assure set up of all required equipment and clean up after; provide oxygen as ordered; and provide respiratory treatment as ordered. Review of a care plan dated 04/02/25 revealed Resident #2 had an alteration in respiratory function and required a tracheostomy and ventilator. Goals included oxygen level to be kept at desired levels set per provider through the review date. Interventions included but were not limited to administer oxygen as ordered; aerosol treatments as ordered; change aerosol nebulizer set-up as ordered; change closed suction catheter system as ordered; change heated moisture exchange as ordered; change size six Shiley tracheostomy inner cannula as ordered; change trach ties as ordered; change ventilator circuit as ordered; cleanse tracheostomy site as ordered; ensure ventilator is on proper settings per orders: AC/VC via tracheostomy continuous, PC 22, RR 20, I time 1.2, PEEP 6, FIO2 32%, ventilator checks every four hours; medications as ordered; monitor lung sounds as ordered; monitor oxygen levels as ordered; and observe for signs and symptoms of dyspnea: labored respiration, low oxygen, use of accessory muscles, cyanosis, changes in mental status, and tachypnea; provide inhalers as ordered; respiratory therapist to change tracheostomy tube every 35 to 40 days and as needed; and suction trach per orders. Review of orders dated 12/24/25 revealed Resident #2's ventilator circuit needed changed monthly and as needed, HME needed changed daily and as needed, a respiratory therapist was to change tracheostomy tube every 30 to 45 days and as needed with a size six Shiley, change size six Shiley tracheostomy inner cannula every shift and as needed, and cleanse tracheostomy site with sterile water, pat dry, and apply a drain sponge every shift and as needed. Review of staffing schedules from 12/25/25 through 12/31/25 revealed on 12/26/25 for nightshift (6:00 P.M. to 6:00 A.M.) there were three licensed practical nurses (LPNs) working and no Respiratory Therapists (RTs) or Registered Nurses (RNs). Interview on 01/28/26 at 3:34 P.M. with the Director of Nursing (DON) confirmed there was not an RN or RT working the nightshift of 12/26/25, but there were three LPNs. The DON stated he felt since there was an RN in the building eight hours earlier in the day as required, there did not need to be one at night. When asked if an LPN was permitted to provide ventilator care without the supervision of an RN or RT, he stated since the LPNs received an education and watched ventilator care being performed, he felt the LPNs could work with ventilator residents without supervision despite lack of certification or return demonstration completed. The DON was not sure if ventilator care was in the scope of an LPN's practice. Review of the National Library of Medicine literature dated 08/08/23 revealed mechanical ventilators are sophisticated and require training to ensure positive outcomes and limit harm. Inappropriate setting changes, failure to change alarms, changing settings without appropriate orders, and failure to communicate changes to the medical team result in poor patient outcomes. The individual who is best equipped suited to manage, adjust and document the ventilator is the respiratory therapist and the number of healthcare professionals who are allowed to make adjustments to the ventilator should be limited. All ventilators have alarms when there is a change in ventilation and it is vital to know what to do. This deficiency represents non-compliance investigated under Complaint Number 2702282.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366443	A. Building B. Wing	01/30/2026

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility assessment and interview, the facility failed to ensure the facility assessment was completed accurately. This had the potential to affect all residents in the facility. The facility census was 49. Findings include:Review of the facility assessment dated [DATE] revealed the facility treats a wide range of patients transitioning from hospital to home. Prior to the admission of any resident, the Director of Nursing (DON) along with the interdisciplinary team would assess the physical and psychosocial needs to determine if placement is appropriate. Prior to a new admission arriving at the facility, all care related items not currently in the facility are ordered. Special treatments that could be completed in the facility included, but were not limited to, respiratory treatments. Respiratory treatments that could be completed in the building included oxygen therapy (15), suctioning (5), tracheostomy care (0), and ventilator or respirator care (2). Further review of the facility assessment did not include information of staffing needs for residents receiving respiratory services. Interview on 01/22/26 at 4:32 A.M. with Respiratory Therapist (RT) #172 revealed there were two residents with a tracheostomy and two residents with ventilators. Interview on 01/28/26 at 1:14 P.M. with the Administrator revealed in the facility assessment, they entered the average number of residents they usually have with the care needs rather than the number of residents the facility is able to provide care for based on their needs. The Administrator stated they were able to admit ten residents with ventilators in the facility. The Administrator confirmed the facility assessment was not completed based on what services they were able to provide, but rather the average number of residents they have needing those services, and there was no specific number of staffing requirements or types listed to address the needs of those residents on a ventilator or receiving trach services. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2702282.