DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER OF BELMOND	1107 SEVENTH STREET NE BELMOND, IA 50421

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F 000 ✓	INITIAL COMMENTS Correction date: 5/17/25 The Rehabilitation Center of Belmond Nursing Home is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities due to the following deficiencies written during the facility's annual recertification survey conducted on April 14, 2025 to April 17, 2025. Total census: 30	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, staff interviews, and policy review the facility failed to assure a resident with a pressure ulcer received treatment and services, consistent with professional standards of practice, to promote healing of an unstageable pressure ulcer for 1 of 2 residents reviewed (Resident #24). The facility reported a census of 30 residents.	F 686		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Monica Freerks
TITLE: Provisional Administrator
(X6) DATE: 5/1/25

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.

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Finding include:

The Minimum Data Set (MDS) assessment identifies the following definition of pressure ulcers:

Stage I is an intact skin with non blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only, it may appear with persistent blue or purple hues.

Stage II is a partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, with slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.

Stage III is full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but didn't obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue) which may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.

Unstageable Ulcer: inability to see the wound.

Other staging considerations include:

Deep Tissue Pressure Injury (DTPI): Persistent non blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non blanchable deep red, maroon,

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purple discoloration due to damage of underlying tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent skin. 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.

Resident #24's Minimum Data Set (MDS) assessment dated 1/2/25 identified a Brief Interview for Mental Status (BIMs) score of 15, indicating intact cognition. The MDS listed Resident #24 as independent with bed mobility and transfers. The MDS included diagnoses of coronary artery disease, hypertension (high blood pressure), renal disease (kidney), emphysema, adult failure to thrive, and nonrheumatic aortic valve stenosis (narrowing of aortic valve). The MDS documented Resident #24 didn't have a risk for developing pressure ulcer/injuries and didn't have any unhealed pressure ulcers/injuries. The MDS reflected Resident #24 received hospice care.

The Care Plan Focus with a target date of 1/20/25 indicated Resident #24 had a potential for pressure ulcer development related to his disease process. The Care Plan directed the following interventions:
Staff to apply lotion to his skin with AM (morning) and HS (bedtime) cares.
-Staff to provide him reminders/occasional assistance to turn/reposition approximately every 2 hours, more often as needed or requested.
-Pressure reducing device on bed and in the wheelchair.

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The Health Status Note dated 1/16/25 at 6:20 AM documented the staff found a fluid filled blister on Resident #24's right inner heel. The nurse painted the area with betadine and covered it with gentle border dressing.

The clinical record lacked documentation of a completed incident report, that someone notified the Physician of the fluid filled blister, and lacked a new skin intervention to reduce pressure to the right heel.

Review of Resident #24 Physician orders lacked a Physician order for the staff to apply betadine and a dressing to the right heel on 1/16/25.

A Non Pressure Skin Condition Record dated 1/16/25 documented Resident #24 complained of right heel pain. A fluid filled blister was observed that measured 3.5 cm (centimeters)(length) x 4.5 cm (width) with a scan amount of serous (clear to pale yellow) drainage. The specialty intervention marked on the form was a chair cushion. The section on the form to address treatment to the area documented NA (not applicable).

The Health Status Note dated 1/17/25 at 9:45 AM documented Resident #24 had a shower that morning. When the nurse removed the dressing from the right heel they saw a small amount of orangish drainage on the dressing. The note described the top portion of the blister as open. The nurse cleaned the area and applied a border dressing for protection. The note indicated they planned to notify the Primary Care Physician (PCP).

The Secure Conversations Note dated 1/18/25 at 10:23 PM reflected the following:

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a. 1/17/25 at 5:31 AM: The facility notified the provider of Resident #24's blister on their right inner heel. The note asked if they could paint the area with skin prep and cover with a gentle border dressing every other day until healed.
b. 1/17/25 at 9:47: The facility reported the blister broke open and had a small amount of orangish drainage on the dressing.
c. 1/18/25 at 8:10 AM: The provider responded they could proceed with skin prep and cover with a gentle border dressing every other day until healed.

A Non Pressure Skin Condition Record dated 1/22/25 documented the right heel measured 4.5 cm x 7 cm and the wound deteriorated. The specialty intervention marked on the form continued as a chair cushion. The progress note on the form documented they couldn't apply the treatment of skin prep due to the wound being open. The note indicated the facility waited for new recommendations from Hospice.

A Hospice Form titled Physician Orders dated 1/22/5 included new orders to clean the area on the right heel with soap and water and apply a Mepilex (foam dressing) to the heel 2 times per week and as needed (PRN).

A form titled Comprehensive Patient Assessment dated 1/24/25 completed by the Hospice Wound Nurse/CWON (Certified Wound Ostomy Nurse) documented the following assessment on Resident #24's right heel wound:
*Etiology: Pressure
*Location: Right Heel
*Size (LxWxD cm): 4.5 x 7 x 0
*Stage: Unstageable
*Edges: Distinct, outline clearly visible, attached,

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even with wound base
*Wound bed: obscured by necrosis
*Granulation: No granulation tissue present
*Epithelialization: < 25 % wound covered
*Necrotic (dead or dying tissue) tissue type: Loosely adherent (still attached to the wound bed) yellow slough (necrotic tissue that builds up on the top of a wound).
*Necrotic tissue amount: 75% to 100% wound covered
*Drainage type: serosanguineous (thin, watery, pale red/pink)
*Drainage amount: small

A form titled Recommended Plan of Treatment with a date of service for 1/24/25 documented the Hospice Wound Nurse/CWON completed a virtual follow up by electronic medical record (EMR) review and photo provided by the Hospice nurse on 1/22/25. The note documented Resident #24 had a new wound to the right heel with current treatment dated 1/22/25 to clean the area with soap and water, dry, and apply a Mepilex, then change 2 times per week and as needed. The form documented new recommendations from the wound nurse: a. Right heel unstageable pressure injury: Cleanse wound, dry, apply small amount of Thera honey to wound bed (yellow slough), cover with Vaseline gauze, abdominal (ABD) pad, and secure with kerlix (stretchy gauze used to wrap around an area of a wound). Change 2 times per week and as needed. b. Offload pressure to bilateral heel by using heel lift boots or pillow. The Wound Nurse signed the treatment recommendations on 1/24/25 and the PCP signed the recommendation orders on 1/27/25. The facility nurse noted the orders on 2/4/25. The time stamp on top of the form indicated the provider faxed the form to the facility

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F 686	Continued From page 6 on 1/27/25 at 9:42 AM. Resident #24's February 2025 Treatment Administration Records (TAR) reflected the facility didn't implement the new treatment orders signed by the Physician on 1/27/25 until 2/5/25 (10 days after the facility received the orders). In addition, the TAR lacked the order to offload pressure by using heel lift boots or pillows. The Care Plan with a target date of 7/13/25 didn't address offloading the heels using heel lift boots or pillows. In addition, the April 2025 TAR and CNA Kardex didn't address offloading Resident #24 heels with heel lift boots or pillows. On 4/16/225 at 9:35 AM, observed Staff C, RN (Registered Nurse), complete Resident #24's right heel dressing change and measurements. Staff C sanitized her hands and applied gloves. She removed the old dressing off the right heel and cleaned the heel wound with wound cleanser. Observed the wound bed have yellow stringy/adherent slough. Staff C removed her gloves, sanitized her hands, and put on clean gloves. Staff C measured the heel wound and reported the size as 2 cm (length) x 3.3 cm (width). Staff C reported the wound looked better. Staff C described the wound bed as 75% dark red tissue and 25% slough. She reported the wound margins with maceration (softening or breakdown of skin from moisture) and small amount of a callus (thickening of the skin) to the upper side of the wound. Staff C reported she still classified the wound as unstageable due the amount of slough and being unable to see underneath that. Staff C removed her gloves, sanitized her hands, put on	F 686		

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new gloves, applied betadine to the heel wound, let the betadine dry, and then covered the wound with a Mepilex dressing. Staff C removed her gloves, sanitized her hands, and put the heel protector boots back on, the she covered Resident #24 up.

On 4/17/25 at 9:00 AM, the DON (Director of Nursing) and the Corporate Nurse reported they expected staff to obtain a physician order when applying a skin treatment. The DON reported they used heel lift boots as a standard intervention when a pressure ulcer develops on a heel. The DON verified the fax number on the top of the form titled Recommended Plan of Treatment was the facility's fax number. The DON acknowledged the time stamp as 1/27/25 at 9:42 AM.

On 4/17/25 at 12:07 PM, the DON verified the facility didn't complete an incident report for Resident #24's pressure area. She reported she didn't know why they didn't implement the Physician's order on 1/27/25 until 2/5/25. She said the nurse who noted the order on 2/4/25 didn't know either. The DON and Corporate Nurse reported they expected the staff to implement the treatment order immediately and obtain the supplies. The DON verified she couldn't locate documentation regarding the heel lift boots under tasks (Kardex), treatment records, or the Care Plan. The DON reported when a resident developed a new pressure ulcer she expected staff to contact the Physician for a treatment order, complete an incident report, notify the family, and put a skin intervention in place.

A facility policy titled Pressure Ulcer Risk Assessment and Documentation revised January

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F 686	Continued From page 8 2011 directed staff to assess any new pressure ulcer as soon as discovered and document the following in the interdisciplinary notes: a. location, stage, size, depth, drainage, odor, color, surround skin condition, location and extent of any undermining or tunneling/sinus tract and granulation. b. Once the area has been assessed, notify the resident and or responsible party, physician, and DON. Document notification in the interdisciplinary notes. c. Obtain treatment orders from the Physician and record the treatments either on the MAR (Medication Administration Record) or TAR. d. Notify the Dietary Manager and they have the responsibility to initiate dietary interventions. e. Update the Care Plan to reflect new intervention to aid in the healing process. f. Update CNA assignments to include new interventions.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		

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§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, staff interview, and policy review the facility failed to assess, provide interventions, or notify the physician, the Registered Dietitian (RD), and the family about a resident with a significant weight loss (over 5% in month) for 1 of 2 residents (Resident #14) reviewed. In 1 months, timeframe, Resident #14 lost greater than 5% of their body weight (considered significant weight loss). The facility failed to notify the RD and physician for interventions to prevent further weight loss. The facility reported a census of 30 residents.

Findings include:

Resident #14's Minimum Data Set (MDS) assessment dated 3/26/25, identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS included diagnoses of cancer and heart disease.

On 4/14/25 at 12:04 PM, observed Resident #14 in the dining room eating lunch.

Resident #14's Weight Summary reviewed 4/15/25 identified the following weights:
a. 3/9/25: 205.3 pounds (lbs.)
b. 4/6/25: 191.4 lbs.
The calculated weight loss percentage revealed a weight loss of 6.92% in 1 month (significant

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considered greater than 5% in 30 days).

The Care Plan Focus with target date 7/13/25, documented Resident #14 had a potential/risk for altered nutritional status. The Goal reflected Resident #14 would maintain their weight without significant changes. The Interventions directed the following:
a. Monitor weights
b. Notify the physician and RD of significant weight changes.

Resident #14's clinical record lacked notification to their physician, RD, or their family of their significant weight loss on 4/6/25.

Interview on 4/16/25 at 5:37 PM, the Assistant Director of Nursing (ADON), reported the previous weight review procedure as to weigh all residents' Sundays, then the past Director of Nursing (DON) reviewed the weights on Mondays. The RD came to the facility every Thursday. The ADON agreed Resident #8 had a significant weight loss from 3/9/25 - 4/6/25 and didn't know if the RD reviewed Resident #14's weight loss on 4/10/25 when she came to the facility. The ADON added the RD reviewed the residents due for their quarterly and annual MDS. She added the facility didn't have a process in place to ensure the RD reviewed weight losses. The ADON stated the staff should have notified the physician, RD, and family Resident #14's significant weight loss. She expected the staff to notify the physician, RD, and family with any significant weight loss.

Interview on 4/17/25 at 9:17 AM, the RD stated she came to the facility every Thursday and completed the dietary assessments for residents

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F 692	Continued From page 11 due for a quarterly or annual MDS, any significant changes, and residents with any skin issues. The RD stated she pulled a report from the facility's charting system for any significant weight changes, but that the reports are not always accurate. The RD stated the facility let her know if they had any concerns such as residents who didn't eat but the facility didn't report to her any significant weight changes. The RD stated she didn't review Resident #14's weight changes on 4/10/24 while at the facility, and the facility didn't notify her of their significant weight loss. The RD stated it would be nice for the facility to notify her of residents' significant weight loss. The undated facility policy labeled Family and Physician Notification Relating to Accident or Change in Medical Condition instructed the facility to immediately notify the resident's responsible party and physician of a change in the resident's medical condition. The guidelines referenced to determine the urgency of notifying the physician and responsible party of changes in medical condition such as report on next work day of a weight loss of 5% or more within 30 days.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		

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by:
Based on observation, record review, and staff interview the facility failed to ensure each resident received necessary respiratory care and services in accordance with professional standards of practice by not changing oxygen (O2) tubing for 1 of 1 resident (Resident #8) reviewed. Facility reported a census of 30 residents.

Findings include:

A Minimum Data Set (MDS) dated 2/19/25for Resident #8, included diagnoses of obstructive sleep apnea (frequent episodes of obstructed breathing while sleeping) and heart failure and received O2. A Brief Interview for Mental Status (BIMS) score of 15 indicated no cognitive impairment.
Therapy.

Observation on 4/15/25 at 9:50AM, in Resident #8's room was an O2 concentrator (machine that supplies O2) with tubing attached to a bipap machine (medical device that provides airway pressure to assist with maintaining breathing). The tubing supplying O2 from the concentrator to the bipap machine was not dated.

Interview on 4/15/25 at 3:38 PM, Resident #8 stated she uses her bipap machine nightly with 2 liters (L) of O2. The resident stated the facility does not change the O2 tubing routinely and she does not know the last time the tubing was changed.

Review of Resident #8's Clinical Physician Orders as of 4/16/25 at 11:46 AM, lacked an order to change O2 tubing.

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F 695	Continued From page 13 Interview on 4/16/25 at 11:39 AM, the Corporate Administrator stated the facility did not have a policy for changing oxygen tubing, that the facility protocol was to change the tubing every Sunday on the 2nd shift. Interview on 4/16/25 at 12:11 PM, the Corporate Administrator confirmed Resident #8 did not have an order to change the O2 tubing and her expectation to have an order and the tubing to be changed weekly.	F 695		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinic record review, staff interviews, and policy review, the facility failed to administer medications per physician orders for 2 out of 2 residents reviewed (Resident #10 and #133) for significant medication errors. Resident #10 didn't receive his insulin medications the morning of 12/15/24. In addition, Resident #10 received short acting insulin with a blood sugar (BS) below 200 mg/dl (milligrams per deciliter) when the physician order directed staff to hold the insulin with a BS below 200 mg/dl. In addition, a nurse gave Resident #133 (a noninsulin treated diabetic) insulin instead of Resident #10 using Resident #10's insulin pen. The facility reported a census of 30 residents. Findings include: 1. Resident #10's Minimum Data Set (MDS)	F 760		

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assessment dated 12/9/24 identified a Brief Interview for Mental Status (BIMs) score of 5, indicating severe cognitive impairment. The MDS listed Resident #10 as independent with bed mobility and transfers. Resident #10 used a walker for ambulation. The MDS included diagnoses of coronary artery disease (impaired heart blood vessels), hypertension (high blood pressure), renal disease, and type 2 diabetes with hyperglycemia (elevated blood sugar). The MDS documented Resident #10 received insulin injections 7 days and took a hypoglycemic medication during the look back period.

A Progress Note titled Incident Report - Medication Event dated 12/15/24 at 1:36 PM reflected Resident #10's Basaglar 17 units and Fiasp 7 units didn't receive his morning dose of insulin, due to the nurse gave it to another resident. The note identified Resident #10's BS as 259 and he didn't show any signs or symptoms of hyperglycemia. The facility notified Resident #10's Physician and his wife of the medication error.

A Progress Note titled Incident Report - Medication Event dated 12/30/24 at 7:18 PM documented Resident #10 blood sugar as 137 at 4:50 PM and he received 7 units of Fiasp insulin. The note indicated the nurse didn't realize the parameter to hold the insulin with a BS below 200 mg/dl. The note documented the facility notified Resident #10's Physician and his wife of the medication error.

An undated facility form titled Medication Administration Times reflected the following schedule:
a. AM = 6:00 AM to 10:00 AM

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b. MM (mid-morning) = 9:00 AM to 12:00 PM
c. MA (midafternoon) = 3:00 PM to 5:00 PM

Resident #10's December 2024 Blood Glucose/Insulin Administration Record directed staff to administer the following insulin medications: a. Basaglar (long acting insulin) KwikPen 100 unit/ml (milliliters), inject 17 units subcutaneously (SQ) one time a day related to type 2 diabetes mellitus with hyperglycemia. The report reflected signatures indicating administration for the following:
i. 12/15/24, the date of Medication Error when Resident #133 received Resident #10's insulin. The record lacked correction of the error.
b. Fiasp (short acting insulin) 100 units/ml inject 7 units before meals. Hold if BS is 200 md/dl or below. The report reflected signatures indicating administration for the following:
i. 12/15/24 AM: the date of Medication Error when Resident #133 received Resident #10's insulin. The record lacked correction of the error.
ii. 12/31/24 MA: BS - 175.

Resident #10's January 2025 Blood Glucose/Insulin Administration Records identified the nurse administered Fiasp Insulin 7 units on the following days/times when he had a documented blood sugar below 200 mg/dl:
*1/1 - AM - BS = 155
*1/4 - AM - BS = 142 *1/4 - MM - BS = 142 *1/10 - AM - BS = 70 *1/10 - MM - BS = 116 *1/12 - AM - BS = 111 *1/12 - MM - BS = 111 *1/13 - AM - BS = 102 *1/22 - MA - BS = 192 *1/24 - AM - BS = 168 *1/24 - MM - BS = 168 *1/25 - AM - BS = 122 *1/26 - AM - BS = 117 *1/29 - MA - BS = 116 *1/30 - MA - BS = 181

Resident #10's February 2025 Insulin

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Administration Records identified the nurse administered Fiasp Insulin 7 units on the following days/times when he had a documented blood sugar below 200:
*2/1 - AM - BS = 103 *2/1 - MM - BS = 144 *2/2 - MA - BS = 166 *2/6 - MA - BS = 117 *2/9 - MA - BS = 130 *2/10 - AM - BS = 179 *2/10 - MM - BS = 179 *2/10 - MA - BS = 135 *2/14 - MA - BS = 157 *2/17 - MA - BS = 128 *2/19 - MA - BS = 154 *2/22 - AM - BS = 131 *2/23 - AM - BS = 151 *2/23 - MM - BS = 151 *2/26 - MM - BS = 183 *2/28 - MM - BS = 194

Resident #10's clinical record lacked notification of his Physician and/or his wife of the medication errors related to the administration of Fiasp insulin on multiple occasions when he had a blood sugar below 200 mg/dl.

On 4/16/25 at 12:04 PM, Staff A, LPN (Licensed Practical Nurse), verified the check mark on the Insulin Administration Record meant the resident received the medication.

On 4/16/25 at 4:30 PM, the Corporate Nurse reported the facility notified Resident #10's Physician regarding the administration of the Fiasp insulin with a BS below 200.

2. Resident #133's MDS assessment dated 10/17/24 identified a BIMs score of 3, indicating severe cognitive impairment. The MDS listed Resident #133 as independent with bed mobility and required partial/moderate assistance with transfers and ambulation. The MDS included diagnoses of hypertension (high blood pressure), renal (kidney) disease, and diabetes mellitus. The MDS documented Resident #133 didn't receive insulin injections and didn't take hypoglycemic

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medication during the lookback period.

A Progress Note titled Incident Report - Medication Event dated 12/15/24 at 12:46 PM reflected the nurse accidentally gave Resident #133 another resident's insulin medication. The note documented Resident #133 received Basaglar insulin 17 units and Fiasp insulin 7 units. According to the note Resident #133 had a BS of 197 at 12:10 PM. The note documented the nurse notified a Physician at 12:15 PM. The Physician gave new orders to check Resident #133's BS every 30 minutes for 4 hours and then every hour until 8:00 PM. The note indicated the facility notified Resident #133's responsible party at 12:20 PM.

A Progress Note titled New Order Follow Up Note dated 12/16/24 at 4:34 AM documented the nurse checked Resident #133's BS every 2 hours without signs and symptoms of hypoglycemia (low blood sugar) noted. His BS ranged from 115 130 mg/dl during the shift.

An untitled facility document provided by the Administrator during the survey documented on 12/15/24, Staff B, LPN, administered Basaglar 17 units and Fiasp 7 units to Resident #133 in error. The investigation documented Staff B went into the wrong room to administer Resident #10's insulin. Staff B discovered the medication error when they gave Resident #10's noon insulin. At that time, they realized she didn't give this resident insulin for his morning dose. The report documented the Pharmacist came to the facility on 1/3/25 to review the medication incident. The facility spoke with Staff B and she reported as she got ready to give insulin to Resident #10, another nurse gave her a freestyle libre (glucose

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monitoring system) for Resident #10. Staff B reported she entered Resident #133's room instead. She reported she looked for the glucose sensor on the resident, but she couldn't find it. She thought maybe he removed it. Staff B reported she checked a fingerstick BS and reported he had a result above 200. Staff B reported she didn't question if she had the correct resident or not because he had an elevated blood sugar. She pulled the insulin from the medication cart and put on new needles. Staff B reported she gave the Basaglar and Fiasp doses to Resident #133. Staff B reported she realized she gave the insulin to the wrong resident when she went to give the noon meal insulin. At that time, she called the ER (Emergency Room) Provider to let him know what happened and received orders to check Resident #133's blood sugar every 30 mins until 4:45 PM then every hour until 8:00 PM then every 2 hours until 6:00 AM. Staff B reported she used the same pen of Fiasp to give the noon dose to Resident #10.

On 4/16/25 at 12:21 PM, Staff B, verified she was the nurse that made the insulin errors with Resident #10 and Resident #133. Staff B described it as literally a freak accident. She reported being new to the facility, worked as an agency nurse, and not 100% familiar with the residents. Staff B reported another nurse handed her a freestyle libre for Resident #10. She said she walked into Resident #133's room, felt his arm, and couldn't locate the glucose sensor, she thought maybe it fell off. Staff B reported when she checked a fingerstick BS, it had a high result. Staff B reported she abandoned the 6 rights of medication administration and made a very bad mistake. She reported she didn't realize until later when she went to give the noon insulins that she

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gave the insulin to the wrong resident. She reported she realized the error when she looked at Resident #10's picture on the medication administration record. She said she went down right away to assess Resident #133 and check his blood sugar. She reported she notified the ER Physician and received new orders to check Resident #133's. She said she also called Resident #133's family. She added she assessed Resident #10 since he didn't receive his morning insulin. She reported Resident #133 didn't respond to the insulin he received. Staff B reported she gave both insulins from an insulin pen. She said she put brand new needles on the insulin pens before she gave the insulin to Resident #133. She reported after she gave the insulin to Resident #133 she disposed of the needles and put the insulin pens back in the drawer in the medication cart. She reported she used the insulin pens to give Resident #10 insulin that day after she had given the insulin to Resident #133. Staff B reported she received a phone call from the DON (Director of Nursing) and a Pharmacist after the medication error occurred. Staff B reported she couldn't recall what day she received the phone call from the DON and Pharmacist. Staff B reported the Pharmacist told her if that ever happened again that it was in the best interest of the patient to discard the insulin pens even if they used a new needle. Staff B reported she didn't know any better at the time. Staff B reported after the medication error occurred she made her own plan to follow the 6 rights of medication administration and complete extra checks to ensure she gave the right medication to the right resident.

A facility form titled One on One Inservice Record

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dated 1/3/25 documented Staff B received a verbal review via phone call, regarding the following topics: a. 6 rights of medication administration b. Inhaler, eye drops, and insulin pens are single patient use c. Discard contaminated medications and obtain new ones for the medication cart.

On 4/16/25 at 3:09 PM, the DON reported she expected staff to follow physician orders for administering the insulin.

A facility policy titled Medication Administration - Medication Pass revised May 2023 defined the purpose of the policy as to safely and accurately prepare and administer medication according to physician order and resident needs. The procedure for medication administration outlined the following steps: a. Open EMAR (electronic medication administration record) to patient record and review physician medication order against medication label b. Read transcribed physician order on EMAR: patient name, medication name, dosage, route and interval ordered
c. Remove medication from cart
d. Compare EMAR with medication label for accuracy e. Read special medication administration instructions f. Obtain vital signs, if applicable, and record results on EMAR g. Prepare medications for administration h. Administer medication
· Knock on door and request entrance
· Introduce self, explain medication administration need and provide privacy
· Identify patient
· Describe name of medication and reason for use to patient and answer any questions if needed

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F 760	Continued From page 21 · Administer medication according to specific procedures A facility policy titled Medication Error and Medication Discrepancy Report revised July 2005 directed to prepare and administer drugs and biologicals in accordance with physician orders, manufacturer's specifications, and accepted professional standards and principals. The policy indicated the facility had systems designed to minimize medication errors. The policy instructed to conduct an investigation and corrective action after discovery of errors to prevent recurrence. The policy defined a significant medication error as one which, in the charge nurse's professional judgment, causes the resident discomfort or jeopardizes their health and safety, based on the resident's condition, the drug category of the medication involved, and the frequency or duration of the error at the time of discovery. A facility policy titled Physician Orders/Transcription of Orders revised July 2023 documented active orders should be followed and carried out as written/transcribed.	F 760		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		

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The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

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F 880	Continued From page 23 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, CDC (Centers for Disease Control and Prevention) recommendations and policy review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents reviewed (Residents #10 and #133). After Resident #133 received Resident #10's insulin via an insulin pen, the facility failed to discard the insulin pens after the cross contamination occurred. The nurse put the insulin pens back into the medication cart after the medication error occurred and the nursing staff continued to use the insulin pens when administering Resident #10's insulin. The facility reported a census of 30 residents. Citation considered past noncompliance as the facility completed the following interventions prior to surveyor entering the building on 4/14/25: a. Staff B, LPN (Licensed Practical Nurse), received verbal education on 1/3/25. b. The facility	F 880	Past noncompliance: no plan of correction required.	

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provided the nurses education on 1/16/23 that insulin pens are single patient use and shouldn't be shared between residents. The nurse should get a new insulin if any cross contamination occurred for the next administration.

Findings include:

Resident #133's Progress Note titled Incident Report - Medication Event dated 12/15/24 at 12:46 PM revealed the nurse accidentally gave Resident #133 another resident's insulin medication.

An untitled facility document provided by the Administrator during the survey documented on 12/15/24, Staff B, LPN, administered Basaglar 17 units and Fiasp 7 units to Resident #133, instead of Resident #10 in error. Staff B discovered the medication error when she gave Resident #10's noon insulin. At that time, she realized she didn't give this resident insulin for his morning dose. Staff B reported she used the same pen of Fiasp to give Resident #10's noon insulin dose.

1. Resident #10's Minimum Data Set (MDS) assessment dated 12/9/24 identified a Brief Interview for Mental Status (BIMs) score of 5, indicating severe cognitive impairment. The MDS listed Resident #10 as independent with bed mobility and transfers. Resident #10 used a walker for ambulation. The MDS included diagnoses of coronary artery disease (impaired heart blood vessels), hypertension (high blood pressure), renal disease, and type 2 diabetes with hyperglycemia (elevated blood sugar). The MDS documented Resident #10 received insulin injections 7 days and took a hypoglycemic medication during the look back period.

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Resident #10's Progress Note dated 1/3/25 documented the facility contacted Resident #10's primary care physician and received orders to obtain HBV, HCV, HIV, VDRL labs on 1/6/25 due to cross contamination with insulin pens on 12/15/24. Resident #10's wife gave consent for labs to be drawn.

Resident #10's Progress Note dated 1/20/25 documented labs results from 1/6/25, HCV, HBV, HIV and VDRL as non reactive.

2. Resident #133's MDS assessment dated 10/17/24 identified a BIMs score of 3, indicating severe cognitive impairment. The MDS listed Resident #133 as independent with bed mobility and required partial/moderate assistance with transfers and ambulation. The MDS included diagnoses of hypertension (high blood pressure), renal (kidney) disease, and diabetes mellitus. The MDS documented Resident #133 didn't receive insulin injections and didn't take hypoglycemic medication during the lookback period.

Resident #133's Progress Note dated 1/3/25 documented the facility contacted the Medical Director and received orders to obtain HBC (Hepatitis B Virus Core Antigen), HCV (Hepatitis C antibody test), HIV (human immunodeficiency virus), VDRL (screen for syphilis) labs on 1/6/25 due to the medication error that occurred on 12/15/24. Resident #133's daughter gave consent to draw the labs.

Resident #133's Progress Note dated 1/20/25 documented labs results from 1/6/25, HCV, HBV, HIV and VDRL as non reactive.

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 _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER OF BELMOND	1107 SEVENTH STREET NE BELMOND, IA 50421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 26	F 880		

A facility form titled One on One Inservice Record dated 1/3/25 documented a verbal review via phone call was completed with Staff B, regarding the following topics: a. 6 rights of medication administration
b. Inhaler, eye drops and insulin pens are single patient use c. Discard contaminated medications and obtain new ones for the medication cart.

A facility form tilted Staff Development Program Attendance Report dated 1/3/25 for Nurses and CMAs included the following education topics:
a. 6 Right of Medication Administration
b. Med Error Process
c. Insulin Administration
d. Inhalers and eye drops.
The education form documented all the facility nurses completed the education as of 1/16/25.

On 4/16/25 at 12:21 PM, Staff B, verified she was the nurse that made the insulin errors with Resident #10 and Resident #133. Staff B described it as literally a freak accident. She reported being new to the facility, worked as an agency nurse, and not 100% familiar with the residents. Staff B reported she abandoned the 6 rights of medication administration and made a very bad mistake. Staff B reported she gave both insulins from an insulin pen. She said she put brand new needles on the insulin pens before she gave the insulin to Resident #133. She reported after she gave the insulin to Resident #133 she disposed of the needles and put the insulin pens back in the drawer in the medication cart. She reported she used the insulin pens to give Resident #10 insulin that day after she gave Resident #133 the insulin. Staff B reported she received a phone call from the DON (Director of Nursing) and a Pharmacist after the medication

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F 880	Continued From page 27	F 880		

error occurred. Staff B reported she couldn't recall what day she received the phone call from the DON and Pharmacist. Staff B reported the Pharmacist told her if that ever happened again that it was in the best interest of the patient to discard the insulin pens even if they used a new needle. Staff B reported she didn't know any better at the time. Staff B reported after the medication error occurred she made her own plan to follow the 6 rights of medication administration and complete extra checks to ensure she gave the right medication to the right resident.

The CDC recommendations dated 8/7/24 described insulin pens as a pen shaped injector device that contain a reservoir for insulin or an insulin cartridge. Each pen is designed to be safe for just one patient to use multiple times with a new, fresh needle for injection. Pens must never be used for more than one patient because blood may be present in the pen after use.

A CDC brochure dated August 2024 documented although visible to the eye, back flow of blood into the insulin pen can happen during an injection. This created a risk for bloodborne and bacterial pathogen transmission to patients if they used a pen for more than one person, even after changing the needle. The CDC recommended if identified of reuse of a pen, the facility should promptly notify patients and offer appropriate follow up including bloodborne pathogen testing.

On 4/16/25 at 3:09 PM, the DON (Director of Nursing) reported she expected insulin pens to be single use and discard an insulin pen if cross contamination occurred. The DON verified the staff continued to use Resident #10 insulin pens

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after cross contamination until the pens were empty. The DON reported she couldn't determine how many doses the insulin pens had left after the cross contamination occurred as they couldn't determine when the staff opened the insulin pens and started to use them. The DON reported when she learned on 1/3/25 that no one discarded the insulin pens after the cross contamination she sent staff education via text message.

A facility policy titled Infection Control Manual Exposure Control Plan revised March 2024 documented if a source patient is determined and the HBV, HCV, and HIV antibody status is unknown, obtain patient consent for blood testing. Inform the source person or legally authorized representative of the incident, and obtain informed consent to test the source's blood, in accordance with applicable state and local laws, to determine the presence of HBV, HCV, or HIV. Testing to determine HBV, HCV, and HIV infection status of the exposure source should be performed as soon as possible after the exposure.

Rehabilitation Center of Belmond

1107 7th Street NE • Belmond, IA 50421 • Ph: (641) 444-3915

Plan of Correction (POC) related to survey completed: 4/17/25
Date POC submitted to DIAL: 5/7/25

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited or as an agreement that the facts stated by DIAL are accurate or complete. This plan of correction is prepared solely because it is required under federal or state law.

F000 Correction Date: 5/17/25

For the required Plan of Correction, the facility submits the following:

F 686- Treatment /Services to prevent/heal pressure ulcer

1. Resident #24's care plan was reviewed on 4/14/2025 to ensure appropriate pressure ulcer treatment and prevention interventions are in place, and alignment with the Hospice provider plan of care.
2. On 4/17/25 education was provided to certified medication aides (CMA) and nurses on timely assessment, intervention and notifications of pressure ulcers.
3. Pressure ulcer documentation will be reviewed 3x/week x 1 month then monthly x 3 months though the facility's quality assurance process. The frequency thereafter will be based on outcomes.

F 692 Nutrition/Hydration status maintenance

1. On 4/15/25 the Primary Care Provider (PCP), was notified Resident #14 had a weight change on 4/6/2025. Provider responded with no new orders. Resident was re-educated to avoid limiting his intake as a self-imposed dietary restriction; protein calories are needed for wound healing.
   On 4/17/25 PCP was notified that Resident #12 had a significant weight change on 4/6/2025. He was reweighed on 4/15/25 with normalized weight. No new orders were received.
2. Residents who receive weekly weights will be reviewed 1x/week by the interdisciplinary team to ensure the process is followed to conduct reweights as needed and notifications of significant changes. Nursing staff and dietary manager received education on 5/14/2025 regarding content of these weekly meetings.
3. Through the facility quality assurance process significant weight changes will be reviewed to ensure appropriate follow up weekly x 4 weeks then monthly. The frequency thereafter will be based on outcomes.

F 695 Respiratory/Tracheostomy Care and Suctioning

1. Resident #8's weekly oxygen tubing change task was added to the medication administration records (MAR) on 4/16/25.
2. Nursing staff received education on 5/14/2025 regarding weekly oxygen tubing changes and MAR tracking. A task reminder for oxygen tubing weekly changes was added to the admission checklist.
3. Through the facility quality assurance process the Director of Nursing (DON) or designee will audit oxygen tubing changes weekly x 4 weeks then monthly x 2 months.

F 760 Residents are free of significant Medication errors

1. Lab work was completed per provider order on 1/6/2025 for Res #10 and Res #133 with no adverse findings or further orders.

2. Re-education was provided to nurses and medication aids on 04/17/2025 of the six rights of medication administration, and safe injection practices.
3. Medication administration audits will be completed weekly x 3 months by DON or designee. The frequency thereafter will be based on outcomes.

F 880 Infection Prevention & Control

1. Lab work was completed per provider order on 1/6/2025 for Res #10 and Res #133 with no adverse findings or further orders.
2. Re-education was provided to nurses and medication aids on 04/17/2025 of the six rights of medication administration, and safe injection practices.
3. Medication administration audits will be completed weekly x 3 months by DON or designee. The frequency thereafter will be based on outcomes.