STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165349	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Plaine Specialty Care	1505 Sunset Drive Belle Plaine, IA 52208

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, staff interviews the facility failed to follow physician orders by administering medication intended for one resident to another resident, for one of six residents sampled (Resident #1). The facility reported a census of 36 residents. The facility corrected the deficient practice per past noncompliance through the following actions: -Education with nursing staff on 1/3/26 regarding rights of medication administration.Findings include: Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 revealed the resident scored 10 out of 15 on a Brief Interview for Mental Status Exam (BIMS), which indicated moderately impaired cognition.Review of the resident's Care Plan revealed the resident was non-ambulatory, and used a wheelchair.The Progress Note for Resident #1 signed on 1/3/26 at 8:57 AM by the Advanced Registered Nurse Practitioner (ARNP) documented the resident received medications he does not normally take in error. The medications received included aspirin (anti-inflammatory), buspirone (for anxiety), calcium (vitamin), carvedilol (slows heart beat and lowers blood pressure), vitamin D (vitamin), glipizide (lowers blood sugar) , isosorbide (relaxes blood vessels to decrease cardiac), jardiance (lowers blood sugar), lisinopril (lowers blood pressure), metformin (lowers blood sugar), and tamsulosin (for enlarged prostate).During an interview on 1/21/26 at 12:36 PM, Staff A, Licensed Practical Nurse (LPN) explained she was new to the facility. It was only her second shift. She explained she was being observed by Staff B, LPN. Staff B told her Resident # 6 was in the dining room and she could give his medications. She got the medications ready and asked for clarification which resident was Resident #6. She administered the medications to the resident she thought was Resident #6, but was actually Resident #1. She even called Resident #1 by Resident #6's name and he responded. Staff B alerted her she was at the wrong resident when she was about to administer eye drops. She explained the doctor, family and hospice were all notified of the error. She did not administer any more medications that day. During an interview on 1/21/26 at 1:58 PM, Staff B explained she was orienting Staff A. Staff A was passing medications. Staff B told Staff A to get Resident #6's medications ready and she could wait if she wanted to for Staff B to return from using the restroom. She did identify Resident #6 for Staff A but assumed she would wait. She did not tell or ask Staff A to wait for her return. She returned and saw Staff A about to administer eye drops to Resident #1, who does not receive eye drops. She verified with Staff A that Resident #1 received the medications intended for Resident #6. She notified the doctor. During an interview on 1/22/26 at 12:44 PM, the Director of Nursing (DON) explained a nurse on their second day of orientations should never be left alone. Someone should be with them as they prepared the medications and walk up to the resident with them. She explained her expectation for training a new nurse, the person doing the training would not leave the new nurse's side. The facility policy titled Administering Medications, last revised 4/2019, directed staff to verify the resident's identity by checking the photograph in the medical record and if necessary, verify with other facility personnel.

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