STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155850	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belltower Health & Rehabilitation Center	5805 North Fir Road Granger, IN 46530

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician orders were carried out timely for 1 of 3 residents reviewed for urinary tract infection. (Resident B). Finding includes:On 10/27/25, Resident B's medical record was reviewed. Diagnoses included but were not limited to dementia, type 2 diabetes, morbid obesity, chronic obstructive pulmonary disease, rheumatoid arthritis, urinary tract infection, hypertension, history of breast cancer, depression, and chronic kidney disease.Resident B's most recent comprehensive Minimum Data Set (MDS) assessment was a Quarterly assessment dated [DATE]. The Assessment indicated Resident B was able to communicate with others, made herself understood and understood others, had moderate cognitive impairment, and demonstrated no negative behaviors. The resident required substantial assistance for personal hygiene, toileting hygiene, bathing, and partial assistance for transferring, was frequently incontinent of bladder and bowel and was at risk for pressure sores, but did not pressure sores at the time of the evaluation. Resident B also utilized a wheelchair for locomotion.Resident B's Physician Order Report included but was not limited to the following orders,Nephrology appointment on 8/22/25 at 1:30 P.M., facility to transport. Obtain a UA (urinalysis) dip and if positive send to the lab for culture and sensitivity testing, for a urinary tract infection, dated 9/17/25.Obtain a UA with culture and sensitivity testing if indicated, post antibiotic treatment for urinary tract infection, dated 10/6/25. Resident B's Nurse's Progress Notes included but were not limited to,9/23/25 at 8:50 A.M., related to the order to collect urine for testing on 9/17/25, indicated the urine had been obtained, had been sent to the lab, and the facility was waiting for the test results.9/24/25 at 11:03 A.M. the progress note indicated UA results were received and now waiting for the culture results.10/09/25 at 5:28 A.M., relating to the order to collect urine for testing on 10/6/25, indicated a urine specimen was collected, and the lab was called for pick up.10/10/25 at 2:09 P.M., the note indicated the UA results were received, the physician was notified, and the facility was waiting for results from the culture and sensitivity.10/16/25 at 5:29 P.M., indicated the UA test results had been faxed to Resident B's nephrologist on 10/15/25.10/17/25 at 3:56 P.M., Resident B was seen by the nephrologist and orders were received to begin Cipro 500 mg by mouth every day for 14 days for an urinary tract infection.Review of a urinalysis result, dated 9/22/25, indicated a urine sample was collected from the resident on 9/22/25 at 8:00 P.M. and indicated the presence of bacteria. The test had been sent for culture testing.Review of a urinalysis result, dated 10/9/25, indicated a urine sample was collected from the resident on 10/9/25 at 5:00 A.M. and indicated the presence of bacteria and had been sent for culture testing.On 10/29/25 at 3:00 P.M., test results for the culture and sensitivity from orders on 9/17/25 and 10/6/25 were requested from the Director of Nursing, but were not provided.During an interview on 10/29/25 at 1:10 P.M., the Administrator indicated Resident B had not been transported to her Nephrology consult appointment on 8/22/25 because of scheduling confusion. The Administrator indicated the resident should have been (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transported to the appointment by facility transportation as ordered. The Administrator indicated there was a delay in collecting Resident B's urine for testing on 9/17/25 and on 10/6/25 and that culture and sensitivity results had taken longer than facility policy's expectations.During an interview on 10/29/25 at 3:00 P.M., the Director of Nursing indicated there had been a delay in collecting Resident B's urine for testing that was ordered on 9/17/25 because collecting urine from the resident was difficult. She indicated the urine was not collected until 9/22/25 and had been sent to the lab for testing and was found to be positive for infection on 9/24/25. The Director of Nursing indicated the results were sent on for culture and sensitivity testing as ordered, to determine the appropriate antibiotic for treatment. The Director of Nursing was not certain when the culture results had been received by the facility, but an antibiotic was initiated on 9/26/25 per a physician's order. The Director of Nursing indicated the urine sample should have been collected when ordered and there had been a delay from the time of the order to the collection of the urine. The Director of Nursing indicated when the physician ordered the urinalysis on 10/6/25, the sample was not collected until 10/9/25 and again there had been a delay in collecting the urine for testing. The Director of Nursing indicated the culture and sensitivity result for the urinalysis order on 10/6/25 was not received until 10/17/25 and was positive for infection. The Director of Nursing indicated the facility had not request an order for the culture and an order was not made to collect urine samples through a catheter. The Director of Nursing indicated urine culture results often took six days to obtain and that nursing standards indicated test results should have been obtained in 24 to 48 hours after the urine had been received by the laboratory.During an interview on 10/29/25 at 3:29 P.M., the Nurse Practitioner indicated the facility had not notified her of the delay in obtaining urine samples for the urinalysis ordered on 9/17/25 or 10/6/25 and that the time between the order and the collection time was delayed. The Nurse Practitioner indicated there had been a long delay in receiving the culture and sensitivity results and those results should have been obtained in one to two days after the urinalysis results were received. The Nurse Practitioner indicated when urine samples were difficult to obtain, straight catheterization was an option. She indicated she had not ordered a straight catheterization because she was not aware of the delays in the urine collection.On 10/29/25 at 2:00 P.M., a policy titled, LEADERSHIP POLICIES AND PROCEDURES.TRANSPORTATION POLICY was provided by the Administrator indicating it was the current facility policy. The policy indicated, .The Facility Provides safe and efficient transportation as available. to meet patient and resident needs.Transportation is provided for medical appointments.On 10/29/25 at 2:00 P.M., a policy titled Physician Orders was provided by the Director of Nursing indicating it was the current policy. The policy indicated, .The qualified licensed nurse will obtain and transcribe orders according to Facility Practice Guidelines.On 10/29/25 at 3:00 P.M., policies regarding following physician orders for urinalysis testing were requested but not provided.This citation relates to Intake 2650865. 3.1-37(a)(b)