

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Belmont Terrace Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 Woodspoint Drive Florence, KY 41042	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of the facility's policies, the facility failed to 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 for 1 of 6 sampled residents reviewed for infection control, Resident (R) 65. Observation on 06/11/2026 on the 100 Unit Hall of medication administration for R65 revealed Licensed Practical Nurse (LPN) 4 dispensed R65's medication from a blister pack into his bare hand and then into the medicine cup. Continued observation revealed LPN4 used his bare hands to break scored medication in half, and then he placed it into the medicine cup. The findings include: Review of the facility's policy titled, Infection Control, reviewed 08/20/2025, revealed facility infection control policies and practices were intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Further review revealed infection control policies and practices were to prevent, detect, investigate, and control infections in the facility. Review of the facility's policy titled, Medication Administration Policy, dated 08/04/2024, revealed if breaking tablets was necessary to administer the proper dose, hands were washed or sanitized, and gloves were applied prior to handling tablets. Per the policy, a tablet-splitter could be used to avoid hand contact with the tablet. Alternately, gloves should be used by the nurse splitting the tablet. Review of an admission Record, found in R65's electronic medical record (EMR), revealed the facility admitted R65 on 04/10/2026 with diagnoses to include infection and inflammatory reaction due to internal left knee prosthesis, subsequent encounter; traumatic arthropathy, left knee; and acquired absence of left knee. Review of R65's admission Minimum Data Set [MDS], found in R65's EMR, with an Assessment Reference Date (ARD) of 04/15/2026, revealed a Brief Interview for Mental Status [BIMS] score of 15 out of 15, which indicated the resident was cognitively intact. Review of the Comprehensive Care Plan, dated 04/15/2026, revealed R65 was care planned for enhanced barrier precautions due to chronic infection of the internal left knee prosthesis. Interventions initiated on 04/15/2026, included staff using personal protective equipment (PPE) when providing care for R65. Observation on 06/11/2026 at 7:12 AM of medication administration on the 100 Unit revealed LPN4 dispensed medication for R65 of pantoprazole 40 mg tablet (used to treat excess stomach acid) from a blister pack into his bare hand and dropped it into the medicine cup and sertraline two tablets (used to treat depression) from a blister pack into his bare hand and dropped them into the medicine cup. LPN4 then retrieved one sertraline tablet and broke it in half with his bare hands and placed 1/2 of the tablet into the medication already in the medicine cup and discarded the other 1/2 tablet into the waste receptacle. LPN4 then dispensed one nifedipine 60 mg tablet (used to lower blood pressure) from the blister pack into his bare hand and dropped it into the medicine cup. During an interview with LPN4 at the time of the observation, he stated the medication should be dispensed from the blister pack directly into the medication cup. LPN4 stated he knew he dispensed (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medication into his bare hand, but he should have put the medication directly into the medicine cup. LPN4 discarded the pulled medications and repulled the medications. LPN4 then dispensed one sertraline tablet into the medicine cup but dispensed the other sertraline tablet into his bare hand to break it apart. When asked if he was aware he used bare hands, LPN4 stated he forgot. LPN4 then donned gloves and dispensed one sertraline tablet into his gloved hands and broke it in half. LPN4 stated the impact to residents from having their medications in his bare hands could be contaminated medications that would be passed to the residents. LPN4 stated there was a pill splitter on the medication cart, but the sertraline tablet was scored, and the pill splitter was not needed. During an interview on 06/11/2026 at 9:40 AM with LPN5 on the 200 Unit, she stated medications were dispensed from the blister pack into the medication cup. LPN5 stated bare hands were not used because it would create an infection control issue for the resident. During an interview on 06/11/2026 at 9:47 AM with LPN8 on the 300 Unit, she stated the medication was dispensed from the blister pack into the medication cup. LPN8 stated if the medication popped out of the cup, gloves were put on, and the medication was wasted. Then, she stated another dose of medication was dispensed into the medication cup. LPN8 stated using bare hands in touching medication would be an infection control problem if the resident received medications from staff not wearing gloves. During an interview on 06/11/2026 at 9:50 AM with Kentucky Medication Aide (KMA) 1 on the 300 Unit, she stated she put on gloves, picked up the medication, and disposed of the medication if it popped out of the medicine cup. KMA1 stated not to touch medication with bare hands due to the possibility of infecting the resident. During an interview on 06/11/2026 at 10:00 AM with Registered Nurse (RN) 1 on the 100 Unit, she stated hands were sanitized and gloves were worn when handling medication to be split. RN1 stated there was a pill splitter on the medication cart used to divide pills. During an interview on 06/11/2026 at 10:13 AM with the 200 Unit Manager, she stated staff was required to sanitize hands and don gloves when handling medication. She stated handling medication with bare hands created an infection control issue which could be transferred to the resident. During an interview on 06/11/2026 at 1:47 PM with the 100 Unit Manager, she stated LPN4 had reported to her that he used his bare hands when handling a resident's medication. She stated when medication came in contact with bare hands it was possible for germs to be transmitted to the resident. During an interview on 06/11/2026 at 2:57 PM with the Infection Preventionist (IP)/Assistant Director of Nursing (ADON), she stated if staff was to touch medications with their bare hands and give to residents, it would create cross-contamination for the residents and put them at risk for infection. During an interview on 06/11/2026 at 4:50 PM with the 200 Unit Manager, she stated it was her expectation for nurses to use gloves if medications need to be split/divided. During an interview on 06/12/2026 at 12:05 PM with the Director of Nursing, she stated it was her expectation for staff to wear gloves when handling medication. During an interview on 06/12/2026 at 12:10 PM with the Administrator, he stated it was his expectation staff would not use bare hands when handling medication. He stated handling medication without gloves would spread germs to residents.		