STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395574	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Terrace	1320 Mill Road Quakertown, PA 18951

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 clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that physician's orders were implemented for one of eight sampled residents. (Resident 1) Findings include: Clinical record review revealed that Resident 1 had diagnoses that included congestive heart failure, atrial fibrillation (irregular rapid heart rhythm that can lead to bloods clots or a stroke), muscle weakness and angiodysplasia of the stomach and duodenum (an abnormality characterized by dilated, fragile blood vessels). The Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident was alert and had pulmonary hypertension (high blood pressure that affects the arteries in the lungs). On April 3, 2025, there was a physician's order that directed staff to schedule a chest X-ray for Resident 1 related to pleural effusion hypoxia (excessive fluid build-up in the lungs), and a physician's order dated April 7, 2025, that directed staff to obtain a stool specimen to rule out clostridium difficile (a bacterial infection of the colon). There was no documented evidence that the chest X-ray was completed, and that the stool specimen was obtained as ordered. In an interview on April 23, 2025, at 2:20 p.m., the Director of Nursing confirmed there was no documented evidence that Resident 1's chest X-ray and stool specimen were completed as ordered. CFR 483.25 Quality of care. Previously cited 8/10/24, 1/16/25 28 Pa. Code 211.12 (d)(1)(5) Nursing services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and interview, it was determined that the facility failed to provide interventions to prevent pressure ulcers for three of eight sampled residents. (Residents 1, 2, 3). Findings include: Clinical record review revealed that Resident 1 had diagnoses that included congestive heart failure, atrial fibrillation (irregular rapid heart rhythm that can lead to bloods clots or a stroke), muscle weakness, pulmonary hypertension (high blood pressure that affects the arteries in the lungs), and angiodysplasia of stomach and duodenum (an abnormality characterized by dilated, fragile blood vessels). According to the Minimum Data Set (MDS) assessment, dated March 19, 2025, the resident was at risk for pressure ulcers, had limited mobility of her lower legs, and could communicate her needs. On March 12, 2025, a physician's order directed staff to apply heel boots (devices to protect the skin of the feet) while in bed. Review of the comprehensive care plan revealed that the resident was at risk for skin breakdown related to immobility. Multiple observations on April 23, 2025, between 11:30 a.m. and 1:20 p.m., revealed Resident 1 in bed and the heel boots were not applied. Clinical record review revealed that Resident 2 had diagnoses that included vascular dementia (brain damage from impaired blood flow to the brain) diabetes, heart disease, and muscle weakness. The MDS assessment dated [DATE], revealed that the resident was nonresponsive and was at risk for pressure ulcers. On April 20, 2025, a physician's order directed staff to apply Prevalon boots (devices that help reduce the risk of heel pressure injury). Review of the comprehensive care plan revealed that the resident had diabetes and was at risk for skin breakdown related to immobility and medical condition. Multiple observations on April 23, 2025, between 11:20 a.m. and 1:30 p.m., revealed Resident 2 in bed and the Prevalon boots were not applied. Clinical record review revealed that Resident 3 had diagnoses that included diabetes and muscle weakness. The MDS assessment dated [DATE], revealed that the resident was at risk for pressure ulcers and could communicate her needs. On March 29, 2024, the physician's order directed staff to float heels (elevate the lower legs so the heels don't touch the bed) while in bed. On April 23, 2025, at 11:30 a.m., the resident was observed with her heels directly on the bed. In an interview on April 23, 2025, at 2:20 p.m., the Director of Nursing confirmed that Residents 1 and 2 did not have the devices to protect their skin to prevent heel pressure injuries and that Resident 3's lower legs were not elevated as ordered. 28 Pa. Code 211.12 (d)(1)(5) Nursing services.