

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Belle Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, it was determined that the facility failed to maintain the environment in a clean, comfortable, and homelike manner on two of two nursing units. (A and B wing)Findings include: Observations on December 3, 2025, from 10:45 a.m. through 2:00 p.m., and on December 4, 2025, from 10:45 a.m. through 2:00 p.m., revealed the following environmental issues: In the shower room on A wing, the first room to the right of the door had a sink with brown stains and the faucet had white stains on it. The toilet had a black ring inside. In the shower room's central shower area, there were open holes in the wall around the shower valve system where the water flow and temperature were controlled. The bathtub room to the left of the central hallway had a marred wall on the left back side of the room, the bathtub had blue and brown stains inside, around the drain, and on the side wall by the faucet. The bathtub faucet had white stains. The shower stall in the back of the shower room had a brown ring around the floor where the floor met the wall and a large gray stain on the floor. In the bathroom shared by resident rooms [ROOM NUMBERS], there were stains on the mirror, a brown ring on the toilet base, a marred wall behind the toilet, a used brief opened and laying across the top of the bathroom garbage can, and pieces of paper garbage on the floor. In resident room [ROOM NUMBER] (bed 1), there were four plastic wrappers and a large syringe (no needle) on the floor. The clock was displaying the wrong time. In the hallway between resident rooms [ROOM NUMBERS], there was a hole in the wall. In resident room [ROOM NUMBER] (bed 1), there was a plastic lid, tissue, and paper debris on the floor. In resident room [ROOM NUMBER] (bed 1), there was a full can of garbage and paper and food debris on the floor around the bed. In the bathrooms of resident rooms [ROOM NUMBERS], there were marred walls along the length of the wall adjacent to the toilet. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(2.1) Management.		

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on facility policy review, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to assess a resident's capability to self-administer medications for one of 14 sampled residents. (Resident 19) Findings include: Review of the facility policy entitled, Self-Administration of Medications, last reviewed on November 20, 2025, revealed that residents had the right to self-administer medications if the staff and practitioner determined it was clinically appropriate for residents to do so. Clinical record review revealed that Resident 19 had diagnoses that included chronic obstructive pulmonary disease (COPD) and muscle weakness. Review of the Minimum Data Set (MDS) assessment, dated October 10, 2025, revealed that the resident's cognitive ability was intact and that he used oxygen. On October 31, 2025, a consulting specialist physician recommended that Resident 19 start taking an inhaler medication to treat COPD daily and that the patient must have this inhaler in his room to be taken immediately upon awakening. The attending physician noted that he agreed with this recommendation. A review of Resident 19's medication administration record revealed a physician's order dated October 31, 2025, and updated November 14, 2025, directing staff to administer one puff of the inhaler in the morning at 7:00 a.m. There was no indication that Resident 19 was evaluated to self-administer his inhaler medication prior to December 4, 2025. On, December 4, 2025, at 12:05 p.m., Resident 19 was observed sitting in a wheelchair in his room. In an interview at that time, Resident 19 stated that the inhaler medication was not readily available and was locked in the medicine cart. The resident stated that the specialist told him to self-administer it when he awakened. Resident 19 stated that he was very frustrated with the nursing staff for not following the physician's recommendation. In an interview on December 5, 2025, at 12:30 p.m., the Director of Nursing confirmed that the resident was not assessed to self-administer the medication as per the facility policy and the physician's orders prior to December 4, 2025. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment was completed to accurately reflect the current status of two of 14 sampled residents. (Residents 1 and 4) Findings include: Clinical record review revealed that Section C (Brief Interview for Mental Status) of Resident 1's MDS assessment dated [DATE], was incomplete. In an interview on December 3, 2025, at 9:00 a.m., the Administrator confirmed that Resident 1's MDS assessment was incomplete. Clinical record review revealed that Resident 4 received hospice services starting on November 13, 2025. The MDS assessment dated [DATE], incorrectly indicated in Section O (Special treatments, Procedures, Programs) that the resident was not receiving hospice services during the previous seven days. In an interview on December 3, 2025, at 9:59 a.m., the Director of Nursing confirmed that Resident 4's MDS assessment was inaccurate.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan to meet each resident's needs as identified in the comprehensive assessment for one of 14 sampled residents. (Resident 1) Findings include: Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included depression. According to the Minimum Data Set Care Area Assessment summary dated January 22, 2025, the resident's psychotropic drug use was to be addressed in the care plan. Review of the medication administration record from January through December 2025, revealed the resident received an antidepressant (trazodone) during the review period. There was no documented evidence that interventions to address Resident 1's psychotropic drug use were included in the current care plan. In an interview on December 5, 2025, at 10:00 a.m., the Director of Nursing confirmed there was no documented evidence that the care area was addressed Resident 15's current care plan. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, observation, and staff and resident interviews, it was determined that the facility failed to accommodate food preferences for one of 14 sampled residents. (Resident 54) Findings include: Review of the facility's weekly menu revealed that the lunch meal for December 3, 2025, was spaghetti noodles with meat, breadstick, tossed salad, and fruit cocktail. Clinical record review revealed that Resident 54 had diagnoses that included anxiety, gastroesophageal reflux disease, and major depressive disorder. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was alert and able to make her needs known. During an interview on December 3, 2025, at 12:25 p.m., Resident 54 stated that her meals did not match what was on her ticket and she received foods she did not like. On December 3, 2025, at 12:30 p.m., her lunch tray was observed on her bedside table and had spaghetti noodles and meat sauce. Resident 54 stated that she did not like pasta, did not want spaghetti noodles, and would not eat them. The resident's tray card indicated that the resident was on a regular diet and did not like pasta. In an interview on December 5, 2025, at 9:00 a.m., the Administrator stated that the dietary department did not follow Resident 54's food preferences identified on the meal ticket. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b) Management.		

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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 facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to implement enhanced barrier precautions and use of personal protective equipment (PPE) to prevent the spread of infection for one of four sampled residents observed during medication administration. (Resident 4) Findings include: Review of the facility policy entitled, Enhanced Barrier Precautions, last reviewed on November 20, 2025, revealed that staff was to wear a gown and gloves during high contact resident care activities, such as using the resident's feeding tube and for residents with indwelling medical devices to minimize the spread of multidrug resistant organisms. Clinical record review revealed that Resident 4 had diagnoses that included dysphagia (difficulty swallowing) and lung cancer. Review of the Minimum Data Set (MDS) assessment, dated November 18, 2025, revealed that Resident 4 had an enteral feeding tube (a soft plastic tube inserted into the digestive system used to provide nutrition directly through the stomach.) On November 3, 2025, a physician's order directed staff to implement enhanced barrier precautions every shift for infection control. Review of the care plan revealed that Resident 4 received his nutrition and medications through the feeding tube and staff was to follow enhanced barrier precautions when providing care. Observations on December 4, 2025, from 9:15 a.m. to 9:30 a.m., revealed licensed practical nurse (LPN) 1 gave Resident 4 medications and food through Resident 4's feeding tube. LPN 1 did not wear a gown while providing care related to the feeding tube in accordance with the facility policy. In an interview on December 5, 2025, at 8:37 a.m., the Administrator confirmed that LPN 1 should have worn a gown when providing care related to Resident 4's feeding tube. CFR 483.80 Infection Control Previously cited 12/28/23, 8/1/24, 1/16/25 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		