STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395574	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BELLE TERRACE STATE LICENSE NUMBER: **024302**	**1320 MILL ROAD** **QUAKERTOWN, PA 18951**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey, and an Abbreviated survey in response to three complaints completed on January 16, 2025, it was determined that Belle Terrace was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0550 SS=D		F 0550		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0550 SS=D	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	Resident 5 was offered assistance with the remaining portion of her meal but declined. Her sweater was properly cleaned. An audit of current residents was conducted to ensure residents were provided with proper assistance during meals. DON or designee will educate nursing staff on the components of this regulation, with emphasis on ensuring residents are assist/redirected as needed during meals. DON or designee will conduct audits of at meal times to ensure residents are offered assistance/redirected as needed during meals. Audit will be conducted 2x a week x 4 weeks then, 1x a week x 4 weeks then, 2x a month x 2 months then, 1x a month x 2 months. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee until monthly and/or until substantial compliance is met. Quality Monitoring schedule modified based	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/31/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0550 SS=D	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550	on findings during QAPI.	

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F 0550 SS=D	Continued from page 3 Based on clinical record review and observation, it was determined that the facility failed to provide assistance with dining in a manner that promoted dignity for one of 16 sampled residents. (Resident 5) Findings include: Clinical record review revealed that Resident 5 had diagnoses that included dysphagia, dementia, and need for assistance with personal care. Review of the care plan revealed that the resident had neurological deficiencies and a history of weight loss. Review of the Minimum Data Set assessment dated November 5, 2024, revealed that the resident had cognitive impairment. Observation of lunch on January 15, 2025, from 12:25 p.m., through 12:45 p.m., revealed that Resident 5 was sitting at a table with the meal tray on the table with more than 75% of the meal uneaten. There was food on the resident's sweater. The resident proceeded to bite at and lick the food on her sweater. The resident did not obtain utensils or food from her tray and	F 0550		

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F 0550 SS=D	Continued from page 4 continued to chew and suck on her sweater for the remainder of the observation period. The resident was not redirected. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0550		
F 0607 SS=E		F 0607		

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F 0607 SS=E	Continued from page 5 483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F 0607	Employees RN1, RN2, RN3, NA1, NA2 and DA1 files were immediately reviewed and missing documents were obtained. These employees also received abuse training per policy. Current employee files were audited. Any missing documentation or education will be completed. NHA/designee will educate HR on the components of this regulation with emphasis to obtained required documents & employees receiving required education upon hire. NHA or designee with audit new hire files to ensure appropriate documentation & abuse training is present. Audit will be conducted 2x a week x 4 weeks then, 1x a week x 4 weeks then, 2x a month x 2 months then, 1x a month x 2 months. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee until monthly and/or until substantial compliance is met. Quality Monitoring schedule modified based on findings during QAPI.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/31/2025**

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F 0607 SS=E	Continued from page 6 This REQUIREMENT is not met as evidenced by:	F 0607		

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F 0607 SS=E	Continued from page 7 Based on facility policy review, employee file review, and staff interview, it was determined that the facility failed to initiate an employee criminal background check, verify professional license/registration, and/or ensure employees completed required abuse training in a timely manner for six of six newly hired employees. (Employees RN 1, RN 2, RN 3, NA 1, NA 2, DA 1) Findings include: Review of the facility policy entitled, "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property," last reviewed October 10, 2024, revealed that the facility was to screen potential employees for a history of abuse, neglect, or mistreating residents prior to employment. This included attempts to obtain information from previous employers and checking with the appropriate licensing boards and registries. The facility was also to educate staff upon hire and annually thereafter regarding the facility's policy to prevent Abuse, Neglect, and Exploitation	F 0607		

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F 0607 SS=E	Continued from page 8 of residents, and Misappropriation of Resident Property. Review of employee files revealed the following: NA 1 had been working at the facility as a nurse aide since October 21, 2024. The facility failed to conduct a criminal background check. There was a lack of evidence to support that required training to prevent abuse, neglect, and exploitation of residents, and misappropriation of resident property had been completed upon hire. NA 2 had been working at the facility as a nurse aide since December 6, 2024. The facility failed to conduct an inquiry to the State nurse aide registry. There was a lack of evidence to support that required training to prevent abuse, neglect, and exploitation of residents, and misappropriation of resident property had been completed upon hire. RN 1 had been working at the facility as a registered nurse since August 14, 2024. The facility	F 0607		

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F 0607 SS=E	Continued from page 9 failed to collect employment references. There was a lack of evidence to support that required training to prevent abuse, neglect, and exploitation of residents, and misappropriation of resident property had been completed upon hire. RN 2 had been working at the facility as a registered nurse since January 6, 2025. The facility failed to conduct an inquiry to the State licensing authority or gather employment references. There was a lack of evidence to support that required training to prevent abuse, neglect, and exploitation of residents, and misappropriation of resident property had been completed upon hire. RN 3 had been working at the facility as a registered nurse since August 12, 2024. The facility failed to conduct a criminal background check, an inquiry to the State licensing authority, or gather employment references. There was a lack of evidence to support that required training to prevent abuse, neglect, and exploitation of residents, and misappropriation of resident property had been	F 0607		

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F 0607 SS=E	Continued from page 10 completed upon hire. DA 1 had been working at the facility as a dietary aide since December 9, 2024. There was a lack of evidence to support that required training to prevent abuse, neglect, and exploitation of residents, and misappropriation of resident property had been completed upon hire. In an interview on January 16, 2025, at 1:20 p.m., the Administrator confirmed that pre-employment screening and required training had not been completed in a timely manner as per facility policy for the newly hired employees listed above. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.19(3)(7)(8) Personnel policies and procedures.	F 0607		

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F 0609 SS=D	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0609	NHA was notified of allegation of abuse related to Resident 41. Report to DOH will be submitted. A review of current residents was completed over the last 30 days to ensure any allegations of abuse were reports. DON and/or designee will educate staff on the components of this regulation with emphasis on timely reporting of abuse to the NHA. DON or designee will audit abuse allegations for timely reporting to NHA. Audit will be conducted 2x a week x 4 weeks then, 1x a week x 4 weeks then, 2x a month x 2 months then, 1x a month x 2 months. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee until monthly and/or until substantial compliance is met. Quality Monitoring schedule modified based on findings during QAPI.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **02/03/2025**

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F 0609 SS=D	Continued from page 12 Based on facility policy review, clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to report an allegation of abuse to the Administrator and the State Survey Agency for one of 16 sampled residents. (Resident 16) Findings include: Review of the facility policy entitled, "Abuse, Neglect, Exploitation, and Misappropriation of Resident Property," last reviewed October 10, 2024, revealed that all incident and allegations of abuse were to be reported immediately to the administrator or designee. Clinical record review revealed that Resident 41 had diagnoses that included anxiety, cognitive decline, and Alzheimer's disease. On October 12, 2024, staff noted that in the morning during the day (7:00 p.m. to 3:00 p.m.) shift, that Resident 41 put a brief over Resident 16's head. Resident 41 started punching Resident 16 and stated she was going to	F 0609		

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F 0609 SS=D	Continued from page 13 smash her in the face with a heavy object. Resident 41 also stated that she wanted to kill Resident 16 multiple times throughout the shift. There was no evidence that staff notified the Administrator until the evening (3:00 p.m. to 11:00 p.m.) shift. There was no evidence that the facility reported the incident to the State Survey Agency. In an interview on January 16, 2025, at 12:37 p.m., the Director of Nursing (DON) confirmed that staff did not immediately notify the Administrator of the incident per the facility policy. In an interview on January 16, 2025, at 2:40 p.m., the DON confirmed that the facility did not report the incident to the State Survey Agency. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0609		
F 0623 SS=B		F 0623		

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F 0623 SS=B	Continued from page 14 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	Resident 11 and 56 no longer reside in the facility. Unable to retroactively correct for resident 13. All residents have the potential to be affected by this alleged deficient practice, however the facility cannot retroactively correct. DON & NHA will be educated on the components of this regulation with emphasis on the need to provider written notification of transfers. NHA or designee will audit 3 hospital transers to ensure written notification was completed. Audit will be conducted 2x a week x 4 weeks then, 1x a week x 4 weeks then, 2x a month x 2 months then, 1x a month x 2 months. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee until monthly and/or until substantial compliance is met. Quality Monitoring schedule modified based on findings during QAPI.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/31/2025**

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F 0623 SS=B	Continued from page 15 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395574	A. BLDG: __00_____ B. WING: _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0623 SS=B	Continued from page 16 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=B	Continued from page 17 Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident and the resident's representative(s) of transfer(s), including the reasons for the moves and Ombudsman information, in writing upon transfer from the facility for three of three sampled residents who were transferred to the hospital. (Resident 11, 13, 56) Findings include: Clinical record review revealed that Resident 11 was transferred to the hospital on October 12, 2024, after a change in condition. There was no documentation to support that the resident or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. Clinical record review revealed that Resident 13 was transferred to the hospital on December 11, 2024, after a fall and change in condition. There was no documentation to support that the resident	F 0623		

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F 0623 SS=B	Continued from page 18 or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. Clinical record review revealed that Resident 56 was transferred to the hospital on November 4, 2024, after a change in condition. There was no documentation to support that the resident or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. In an interview on January 16, 2025, at 9:35 a.m., the Administrator confirmed that the residents or resident representatives were not given written notices regarding their transfers.	F 0623		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 19 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Resident 40 heels were elevated to float heels. Current residents with orders to float heels were audited to ensure heels were elevated. DON/designee will educate nursing staff on the components of this regulation with emphasis on elevating residents' heels. DON or designee will perform an audit of 5 residents with float heels orders to ensure heels are floated. Audit will be conducted 2x a week x 4 weeks then, 1x a week x 4 weeks then, 2x a month x 2 months then, 1x a month x 2 months. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee until monthly and/or until substantial compliance is met. Quality Monitoring schedule modified based on findings during QAPI.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/31/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395574	A. BLDG: 00 B. WING:	01/16/2025

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F 0684 SS=D	Continued from page 20 Based on clinical record review, observation, and resident interview, it was determined that the facility failed to ensure that physician's orders were implemented for one of 16 sampled residents. (Resident 40) Findings include: Clinical record review revealed that Resident 40 had diagnoses that included heart failure and reduced mobility. According to the Minimum Data Set assessment, dated November 23, 2024, the resident was at risk for pressure ulcers, had limited mobility of her lower legs, and could communicate her needs. On March 12, 2024, the physician ordered that staff "float heels" (elevate the lower leg so the heel doesn't touch the bed) while in bed. On January 14, 2025, at 11:32 a.m., Resident 40 was observed with her heels directly on the bed. That same day at 1:55 p.m., the resident stated that staff had not been floating her heels, and she was observed with her heels directly on the bed. The resident was again observed on January 15, 2025,	F 0684		

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F 0684 SS=D	Continued from page 21 at 9:54 a.m., with her heels directly on the bed. CFR 483.25 Quality of care Previously cited 12/28/23, 8/10/24 28 Pa. Code 211.12 (d)(1)(5) Nursing services.	F 0684		
F 0691 SS=D		F 0691		

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F 0691 SS=D	Continued from page 22 483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0691	Resident 158 received ostomy care immediately. Physician orders for Resident R158 were updated to include ostomy care orders. Current residents with an ostomy were audited to ensure ostomy care physician orders were in place. DON and/or designee is providing staff with education related to timely implementation of ostomy physician orders. DON/designee will perform audit of new admissions to ensure ostomy orders are present. Audit will be conducted 2x a week x 4 weeks then, 1x a week x 4 weeks then, 2x a month x 2 months then, 1x a month x 2 months. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee until monthly and/or until substantial compliance is met. Quality Monitoring schedule modified based on findings during QAPI.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **02/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0691 SS=D	Continued from page 23 Based on clinical record review, and family and staff interview, it was determined that the facility failed to provide ostomy (an opening of the bowel through the abdomen), care in accordance with the resident's care plan for one of one sampled resident who had an ostomy. (Resident 158) Findings include: Review of a facility policy entitled, "Colostomy/Ileostomy Care," last reviewed October 10, 2024, revealed that staff were to document the date and time the ostomy care was provided, as well as, the name and title of the person who provided the care in the resident's medical record. Clinical record review revealed that Resident 158 was admitted to the facility on January 8, 2025, and had a diagnoses that included Dementia. Review of the care plan revealed that the resident had an ileostomy. The interventions were for staff to keep the skin around the stoma clean and dry, monitor the skin for irritation, and observe the stoma for unusual	F 0691		

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F 0691 SS=D	Continued from page 24 changes. In an interview on January 14, 2025, at 12:35 p.m., the resident's family member reported that the resident's ostomy supplies had not been changed since admission. There was a lack of evidence in the clinical record to support that staff provided ostomy care or changed the supplies prior to January 14, 2025. There were no physician orders for ostomy care in place until January 14, 2025, six days after the resident was admitted to the facility. The physician orders dated January 14, 2025, directed staff to change the ileostomy wafer every three days and change the ileostomy bag once daily or as needed. In an interview on January 16, 2025, at 11:10 a.m., and 12:54 p.m., the Director of Nursing confirmed that there was no documented evidence that staff changed the resident's ostomy supplies or provided ostomy care prior to January 14, 2025, and that ostomy care should be documented in the resident's	F 0691		

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F 0691 SS=D	Continued from page 25 clinical record. 211.12(d)(1)(5) Nursing services.	F 0691		
F 0756 SS=D		F 0756		

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F 0756 SS=D	Continued from page 26 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	Unabe to retroactively correct for Resident 41. An audit of current resident's pharmacy recommendations over the last 30 days were reviewed to ensure they were presented to the provider for review. DON will be educated on the components of this regulation, with emphasis on ensuring pharmacy recommendations are addressed timely. DON/designee will perform audit of 5 pharmacy recommendations. Audit will be conducted 2x a week x 4 weeks then, 1x a week x 4 weeks then, 2x a month x 2 months then, 1x a month x 2 months. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee until monthly and/or until substantial compliance is met. Quality Monitoring schedule modified based on findings during QAPI.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/31/2025**

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F 0756 SS=D	Continued from page 27 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756		

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F 0756 SS=D	Continued from page 28 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that pharmacy recommendations were reviewed by the physician in a timely manner for one of 16 sampled residents. (Resident 41) Findings include: Clinical record review revealed that Resident 41 had diagnoses that included anxiety and Alzheimer's disease. Review of a pharmacist's recommendation dated August 1, 2024, revealed that the pharmacist noted that the resident was prescribed melatonin and trazodone at hour of sleep (HS). The pharmacist recommended that the physician review the need for both medications and determine if the melatonin could be discontinued to reduce the resident's amount of medication. There was no evidence that the physician addressed the pharmacist's recommendations until October 1, 2024, or that the melatonin was discontinued until October 2, 2024.	F 0756		

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F 0756 SS=D	Continued from page 29 In an interview on January 16, 2025, at 12:37 p.m., the Director of Nursing stated that pharmacy recommendations should be addressed by the physician within five to seven days and there was no evidence that the physician addressed the pharmacy recommendation until October 1, 2024. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0756		
F 0868 SS=D		F 0868		

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F 0868 SS=D	Continued from page 30 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) QAA Committee §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member	F 0868	Unable to retroactively correct this alleged deficient practice. No residents were identified to have been affected by this alleged deficient practice. NHA educated on the components of this regulation with emphasis on the need for the Medical Director to attend the QAPI Meetings. RDCS will audit QAPI sign in sheets to ensure Medical Director is present at least quarterly for QAPI meetings. Audit will be conducted 2x a week x 4 weeks then, 1x a week x 4 weeks then, 2x a month x 2 months then, 1x a month x 2 months. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee until monthly and/or until substantial compliance is met. Quality Monitoring schedule modified based on findings during QAPI.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/31/2025**

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F 0868 SS=D	Continued from page 31 of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:	F 0868		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395574	A. BLDG: __00_____ B. WING: _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BELLE TERRACE STATE LICENSE NUMBER: **024302**	**1320 MILL ROAD QUAKERTOWN, PA 18951**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0868 SS=D	Continued from page 32 Based on review of facility documents and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for two of four quarterly meetings, the first and fourth, of 2024. Findings include: Review of the facility ' s Quality Assurance and Performance Improvement (QAPI) sign-in sheets and attendance records for meetings held in the first quarter of 2024 revealed the facility's Medical Director failed to attend. Review of facility ' s monthly Quality Assurance and Performance Improvement (QAPI) sign-in sheets and attendance records for meetings held in the fourth quarter of 2024 revealed the facility's Medical Director failed to attend. In an interview on January 16, 2025, at 11:39 a.m., the Administrator confirmed that the Medical	F 0868		

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F 0868 SS=D	Continued from page 33 Director did not attend all of the quarterly meetings. 28 Pa Code: 201.18(e)(1)(2)(3) Management.	F 0868		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 34 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Unable to retroactively correct this alleged deficient practice. Resident 27 & 35 had no negative outcome related to alleged deficient practice. MD1 & LPN1 were provided education on EBP. An audit of current residents will be completed to ensure EBP is being followed by staff. DON/designee will educate direct care staff on the components of this regulation with emphasis on Enhance Barrier Precautions. DON/designee will conduct random audits of staff performing care in EBP rooms to ensure proper PPE is worn. Audit will be conducted 2x a week x 4 weeks then, 1x a week x 4 weeks then, 2x a month x 2 months then, 1x a month x 2 months. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee until monthly and/or until substantial compliance is met. Quality Monitoring schedule modified based on findings during QAPI.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/31/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 35 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 36	F 0880		

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F 0880 SS=D	Continued from page 37 Based on facility policy review, clinical record review, and observation, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection for two of 16 sampled residents. (Residents 27 and 35) Findings include: Review of the facility policy entitled, "Enhanced Barrier Precautions," last reviewed October 10, 2024, revealed that enhanced barrier precautions were to be used with any resident with a wound or medical device during encounters when contact is expected, including during wound care and the care of feeding tubes. Precautions included the use of protective gowns during the high risk activities. Clinical record review revealed that Resident 27 had diagnoses that included a Stage 3 pressure sore on his lower back. On January 15, 2025, at 9:06 a.m., a physician (MD 1) was observed entering Resident 27's room to examine his pressure sore. MD 1 did not use a protective gown in accordance with facility	F 0880		

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F 0880 SS=D	Continued from page 38 policy. Clinical record review revealed that Resident 35 had diagnoses that included a history of stroke with difficulty swallowing. She received all nutrition through a feeding tube. On January 14, 2025, at 10:37 a.m., LPN 1 was observed flushing the feeding tube without wearing a gown as required by facility policy. CFR 483.80 Infection Control Previously cited 12/28/23, 8/1/24 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0880		

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P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1) Facility cannot retroactively correct 2) NHA/designee will review CNA staffing ratios for the last 4 weeks to ensure compliance and adherence to regulation. 3) NHA/Designee will re-educate staff scheduler and DON on regulation of CNA staffing ratios to ensure ongoing compliance. Facility will conduct daily staffing meeting to review CNA ratios to ensure ongoing compliance and systematic change. 4) NHA/Designee will conduct audit of projected CNA ratios. Audit will be conducted 2x a week x 4 weeks then, 1x a week x 4 weeks then, 2x a month x 2 months then, 1x a month x 2 months. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee until monthly and/or until substantial compliance is met. Quality Monitoring schedule modified based on findings during QAPI.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/31/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 1 Based on a review of nursing time schedules, it was determined that the facility failed to meet the minimum nurse aide (NA) to resident ratios for eight of 14 days reviewed. Findings include: Review of nursing schedules for 14 days from December 27, 2024 to January 2, 2025, and January 9, 2025, to January 15, 2025, revealed the following: The facility failed to meet the minimum NA to resident ratio of one NA for ten residents on day shift (7:00 a.m. to 3:00 p.m.) on January 9, 11, 12, 13, 14, and 15, 2025. The facility failed to meet the minimum NA to resident ratio of one NA for 11 residents on evening shift (3:00 p.m. to 11:00 p.m.) on January 9, 2025. The facility failed to meet the minimum NA to resident ratio of one NA for 15 residents on night	P 5520		

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P 5520	Continued from page 2 shift (11:00 p.m. to 7:00 a.m.) on December 31, 2024, and January 9, 10, 11, 12, 13, and 15, 2025.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 3 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	1) Facility cannot retroactively correct 2) NHA/designee will review LPN staffing ratios for the last 4 weeks to ensure compliance and adherence to regulation. 3) NHA/Designee will re-educate staff scheduler and DON on regulation of LPN staffing ratios to ensure ongoing compliance. Facility will conduct daily staffing meeting to review LPN ratios to ensure ongoing compliance and systematic change. 4) NHA/Designee will conduct audit of projected LPN ratios. Audit will be conducted 2x a week x 4 weeks then, 1x a week x 4 weeks then, 2x a month x 2 months then, 1x a month x 2 months. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee until monthly and/or until substantial compliance is met. Quality Monitoring schedule modified based on findings during QAPI.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/31/2025**

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P 5530	Continued from page 4 Based on a review of nursing time schedules and staff interview, it was determined that the facility failed to meet the minimum licensed practical nurse (LPN) to resident ratios for nine of 14 days reviewed. Findings include: Review of nursing schedules for 14 days from December 27, 2024 to January 2, 2025, and January 9, 2025, to January 15, 2025, revealed the following: The facility failed to meet the minimum LPN to resident ratio of one LPN for 25 residents on day shift (7:00 a.m. to 3:00 p.m.) on December 27, 28, 29, and 30, 2024, and January 1, 2, 13, 14, and 15, 2025.	P 5530		

Certified End Page

BELLE TERRACE

STATE LICENSE NUMBER: 024302

SURVEY EXIT DATE: 01/16/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY