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 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace Nursing and Rehabilitation Center	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 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

Based on observation, interview, record review, review of the facility's Incident Reports, and review of the facility's policies, the facility failed to keep residents free from abuse and neglect for 3 of 11 sampled residents, Resident (R) 36, R40, and R169.

1. On 02/28/2025, R36 reported to a day shift State Registered Nurse Aide (SRNA) that the previous night shift SRNA purposefully removed his call device from the wall and replaced it with something plastic so he would be unable to use the call device during the previous night shift. The day shift SRNA observed R36's call device was not plugged in, and a plastic device had been put in the call device port.

2. On 11/15/2024, R169 walked into R40's room. R40 hit R169, causing a nose bleed. R40 fell while hitting R169, injuring her ankle.

The findings include:

Review of the facility's policy titled, Abuse Prohibition, revised 07/01/2019, revealed potential hires were screened for history of abuse, neglect, and mistreatment. It also stated potential hires would have a license verification completed, and required background checks were done. Further review revealed all employees received training on abuse prevention, abuse identification, and reporting of abuse. It also stated any employee alleged to have committed an act of abuse would be immediately removed from duty, pending investigation.

Review of the facility's policy titled, Resident Rights, effective date 08/13/2024, stated, The facility will make every effort to support each resident in exercising his/her right to assure that the resident is always treated with respect, kindness, and dignity.

1. Review of R36's admission Record revealed the facility admitted him on 02/23/2023 with diagnoses of functional quadriplegia, autonomic neuropathy, and myoneural disorder with bed confinement status.

(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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R36's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 03/07/2025, revealed a Brief Interview for Mental Status [BIMS], a test for cognitive impairment, was not conducted because resident is rarely/never understood. The assessment of memory/recall ability revealed R36 was able to recall the current season, location of his room, staff name and faces, and where he was currently located and was able to make decisions regarding daily life tasks. Further review revealed R36 did not have any indicators of hallucinations, delusions, no physical or verbal behavioral symptoms, and had functional range of motion limitation on both sides, upper and lower extremities, that made him dependent in all care areas. Review of R36's Care Plan Report, revealed a focus area, initiated on 03/23/2023, of threatening to call state or corporate on staff when need or want could not be met immediately, excessive use of call light, manipulative behaviors, making false accusations of staff, using racial slurs, screaming out, and making sexual remarks to staff. Further review revealed interventions included providing a flat call light to be kept within reach. Review of the facility's Initial Investigation Report, dated 02/28/2025, revealed the incident occurred on 02/27/2025 at approximately 9:00 PM, and R36 reported it to SRNA9 on 02/28/2025 at approximately 3:00 PM. Per the report, upon notification by R36, SRNA9 immediately returned the call light to working order and reported the allegation and findings to management, appropriate notifications were made, and the investigation was initiated. Further review of the report revealed the Administrator interviewed SRNA8, and she admitted to removing the call light from the wall due to being unable to shut off and had forgotten to tell the oncoming shift. Per the report, SRNA8 also stated she had forgotten to place a work order for repair; and SRNA8 was placed on leave pending the investigation. Review of facility's Final/5 Day Investigation Report, dated 03/05/2025, revealed a full investigation was completed and findings substantiated the call light was unplugged, but it could not be proven it was an intentional action. Per the report, all staff received training on call lights and the abuse policy; all residents were interviewed that had a high BIMS; all low BIMS score residents had a skin assessment; and no other issues were identified. The report stated a facility-wide audit of all call lights did not identify any issues with the call system or individual devices, including R36's call device, which was identified to be in working order. Review of SRNA8's employee file revealed a date-of-hire of 04/10/2024. Further review revealed a background check, adult caregiver misconduct registry, sex offender registry, and licensure verification had been performed. Additional review revealed on 04/23/2024, SRNA8 signed she completed and acknowledged the employee code of conduct and the policy for adult protection, abuse, neglect, and resident rights. In an interview with R36 on 04/23/2025 at 9:18 AM, he stated a night shift SRNA removed his call light device from the wall and placed a plastic syringe cap in the port to keep him from being able to use the call light because she did not like him. R36 stated, during the night, he would have verbally called out to get help if needed, and he did not feel isolated, but it made him mad. R36 stated he told the oncoming SRNA the following morning about what the night SRNA did, and she immediately re-connected his call device and told someone. R36 stated he had not seen the SRNA since that incident, had no issues from the event, and had not had any further incidents with his call device. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The State Survey Agency (SSA) Surveyor attempted to interview SRNA8, who no longer worked at the facility, by telephone on 04/22/2025 at 8:00 PM, and a second attempt was made on 04/23/2025 at 7:30 PM. However, with both attempts, there was no answer, and no voicemail was available. The SSA Surveyor attempted to interview SRNA9, who no longer worked at the facility, by telephone on 04/23/2025 at 11:26 AM, but the only available contact number provided was not a working number. In an interview with the Maintenance Director on 04/23/2025 at 9:35 AM, he stated he was involved in the call light audit during the investigation, and no devices or system issues were identified as having malfunctioned, including the specialty call device used by R36. He stated Maintenance was available 24 hours a day by phone, and his contact information was located on all units. He stated any issue with a call device was considered high priority, and a device that was not functioning should have been called into him. He stated he would have come to the facility and replaced or repaired the device if needed. He stated his expectation was for a work order to be placed by staff who identified the issue. He stated review of his work order electronic tracking system revealed no work order was placed on the corresponding dates of the incident for R36's call device. In an interview with the Director of Nursing (DON) on 04/24/2025 at 3:19 PM, she stated abuse of residents by any staff member was unacceptable, and any allegation of abuse or neglect by an employee required immediate suspension. She stated, after any allegation of abuse, mandatory staff education should be instituted based on the specifics of the allegation. She stated the facility doing pre-employment background checks and verifying the abuse registry were important for screening potential employees. In an interview with the Administrator on 04/24/2025 at 2:55 PM, he stated he was notified by a staff member, whom he could not recall, that R36 had complained that a night shift SRNA had purposefully removed his call device from the wall and placed a plastic device in its place, so he would not continue to call out during her shift. The Administrator stated he interviewed R36 who told him the same story, and he made the required notifications. He stated, in his interview with SRNA8, she admitted to removing the device due to a malfunction, and she had forgotten to put in a work order or pass it off to day shift in report. The Administrator stated, during the investigation, all call lights were tested as well as the call system and no malfunctions were identified, including with R36's call device. He stated the finding of the investigation was the event occurred, but intent could not be determined. So, he stated, out of an abundance of caution, SRNA8 was separated from employment. 2. Review of the facility's Investigation Report, dated 11/15/2024, revealed on 11/15/2024, R169 was walking down the 300 Hall when she entered R40's room. Per the report, R40 did not like that R169 was in her room, stood up from her wheelchair, and hit R169 in the face. The report stated when R40 hit R169, R40 fell, hurting her ankle. The report stated R169 had a nosebleed, the physician was notified, and the physician ordered an x-ray for R40's ankle and to monitor R169's nose. The investigation revealed both residents did not remember the incident. Per the report, the residents were immediately separated, and R40 was placed on one-on-one supervision. The report stated both residents' families were notified as well as the physician, Office of Inspector General, Department for Community Based Services, law enforcement, and the Ombudsman. Per the report, a 72 hour psychosocial monitoring was performed which revealed no concerns, and the x-ray of R40's ankle was negative for acute injury. The report stated the facility was able to verify that the incident occurred, and a stop sign was placed on R40's room door to prevent wandering residents from entering. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Review of R40's admission Record revealed the facility admitted the resident on 01/17/2024 with diagnoses to include unspecified dementia, epilepsy, and chronic obstructive pulmonary disease (COPD). Review of R40's quarterly MDS, with an ARD of 10/30/2024, revealed the facility assessed the resident to have a BIMS score of three of 15, indicating R40 was severely cognitively impaired. Observation on 04/24/2025 at 9:56 AM revealed R40 was sitting in a wheelchair. The resident was dressed in street clothes and was clean, with no odors or visible injuries. R40 did not show any signs of fear or anxiety. In an interview with R40 at the time of the observation, she stated she had not been harmed in the facility. She further stated, They better not, my father is a cop. She also stated she felt safe in the facility. b. Review of R169's admission Record revealed the facility admitted the resident on 02/17/2024 with diagnoses which included Alzheimer's disease, glaucoma, and degenerative disease of the nervous system. Review of R169's quarterly MDS, with an ARD of 08/25/2024, revealed the resident was not given a BIMS score because she was rarely/never understood. Observation on 04/24/2025 at 10:04 AM revealed R169 was sitting in the dining room. R169 was clean and did not have any odors or visible injuries. R169 did not show any signs of fear or anxiety. R169 was unable to be interviewed because of her cognitive status. In an interview with SRNA13 on 04/24/2025 at 10:14 AM, she stated she worked the evening of the event, 11/15/2024. SRNA13 stated she was down the hall, and staff heard a noise. She stated she and a nurse ran down the hall, and she heard R40 yell, You better get out of this room. She stated, when she got to the room, she saw R40 hit R169 in the face, and R40 fell. SRNA13 stated she took R169's vital signs and cleaned her nose. She stated R169 was not afraid, but she was confused because she did not know why R40 had hit her. In an interview with Licensed Practical Nurse (LPN) 4 on 04/24/2025 at 10:30 AM, she stated she worked the evening of the event, 11/15/2024. She stated she was at the end of her shift when she heard someone scream. She stated she ran down the hall and saw R40 hit R169 and fall. She stated she helped R40 up, and R40 stated, She [R169] was in my room. She stated she redirected both residents. She stated R40 told her that R40's ankle hurt. She stated R40 was sent out for an ankle x-ray. She stated both residents were placed on 15 minute checks. She stated R169 did not show signs of pain. She stated there had been no change in either residents' behavior. In an interview with the Social Services Director on 04/24/2025 at 2:52 PM, she stated if there was a resident-to-resident altercation, she did a psychosocial visit with each resident for three days. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON) on 04/23/2025 at 3:53 PM, she stated the main thing she did to prevent abuse was to educate staff so they knew if residents had certain behaviors, to monitor them closely. She also stated staff was proactive to prevent abuse. She stated staff met as a team to determine if any changes in resident behavior needed to be addressed. She stated staff did a 72 hour assessment of each resident if there was an altercation. She stated staff was trained to provide individualized care. In an interview with the Administrator on 04/23/2025 at 4:03 PM, he stated the main thing he did to prevent abuse was to do background checks and to train the staff. He stated staff was taught to monitor residents for any change in behaviors, and they knew to keep the residents safe. He stated staff was also taught to report abuse immediately. He stated he talked with residents, and they had resident council meetings. He stated whenever there was an allegation, he interviewed the residents involved. He stated the first thing staff was taught to do was to separate the residents and make sure they were safe. He stated staff then put the residents on one-on-one supervision. He stated he reported all allegations of abuse within two hours.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policies, the facility failed to notify the State Guardian and a representative from the Office of the State Long-Term Care (LTC) Ombudsman of its intentions to discharge a resident and the reasons for the discharge in writing for 1 of 27 sampled residents, Resident (R) 219. R219 was transferred to a Behavioral Health (BH) facility on 11/02/2024 from the facility for a psychiatric evaluation. On 11/11/2024, the Discharge Planner (DCP) at the BH facility notified the State Guardian that after discussions with the facility, the facility would not be accepting R219 back. The facility did not communicate this with the State Guardian or obtain the approval of the State Guardian. Additionally, the facility did not provide a written 30-day notification of transfer/discharge to the State Guardian or the office of the State Long-Term Care Ombudsman. The findings include: Review of the facility's policy titled, Transfer/Discharge Notice, revised 01/27/2025, revealed when the facility anticipated discharge, a post discharge plan of care was developed with the participation of the resident and with the resident's consent. The policy did not address the required 30-day Notice of Transfer/Discharge. Review of the facility's policy titled, Bed Hold, revised 01/27/2025, revealed the facility would provide written information to residents and/or their representatives regarding the bed hold policy. Per the policy, it ensured compliance with federal regulations and state Medicaid requirements while maintaining the rights and care continuity of residents. Review of an Acute Change in Condition Note, dated 11/02/2024 at 12:05 PM, found in R219's electronic medical record (EMR), revealed the resident was combative with staff. According to the note, R219 threw a coffee cup at a nurse and then began throwing computers from the nurse's station after threatening to punch the staff. Additionally, the note stated R219 directed racial slurs toward the staff. Per the note, the nurse failed to document the facility to which the resident was being transferred. According to the note, the State Guardian was not notified. The note stated, Family notification: self. Date notified: 11/02/2024 12:00 PM. Review of a Transfer and Discharge, notification, dated 11/02/2024 at 12:30 PM, revealed it was completed upon R219's transfer to the local emergency room. It stated that R219's Guardian was notified on 11/02/2024. It was recorded that R219 was unable to sign the form. Additionally, it was noted that a copy of the form was mailed to CHFS. However, there was no documentation explaining when, where, or how the form was sent to the responsible party. Review of a General Note, dated 11/02/2024 at 7:00 PM, found in R219's EMR, revealed the facility's nurse spoke to the nurse from the Behavioral Health (BH) facility. The note stated, They will be admitting resident for a 3-10-day program. Resident will discharge back to this facility thereafter. Supervisor notified. Additionally, it was documented that the BH facility would notify R219's State Guardian of the admission. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Discharge Planner Clinical Note, dated 11/08/2024 at 11:44 AM, revealed the Discharge Planner at the BH facility attempted to call the Administrator. The note stated, Writer called [the facility] and asked to speak with an administrator in regard to [R219] Admin did not answer and writer left a VM with call back information. Review of a Discharge Planner Clinical Note, dated 11/08/2024 at 11:50 AM, revealed the Discharge Planner at the BH facility emailed R219's Guardian to inform him of R219's discharge date . According to the note, the Discharge Planner was unable to speak with staff at the facility. Review of an e-mail dated 11/11/2024, from the Discharge Planner at the BH facility to R219's State Guardian, revealed the Discharge Planner informed R219's Guardian that the facility would not readmit R219. Review of a Discharge Planner Clinical Note, dated 11/11/2024 at 12:43 PM, revealed the Discharge Planner at the BH facility called the facility in regard to R219. According to the note, [The facility] is not accepting [R219] and the Dr will not accept him back. Review of a Discharge Planner Clinical Note, dated 11/11/2024 at 12:48 PM, revealed the Discharge Planner at the BH facility emailed R219's Guardian. The note stated the Guardian was emailed informing him that R219 was not able to return to the facility. Review of an email from R219's Guardian to the Discharge Planner at the BH facility on 11/12/2024 at 8:54 AM, revealed the Guardian wrote that he was unaware that the facility would not accept R219 back. Review of an email from the Discharge Planner at the BH facility on 11/12/2024 at 8:59 AM, revealed she told the Guardian that the Director of Nursing at the facility informed her, due to R219's behavior, the facility's physician would no longer treat R219. Review of an email from R219's Guardian to the Discharge Planner at the BH facility on 11/12/2024 at 9:17 AM, revealed the Guardian wrote that he was still trying contact someone with [the facility] about the situation and the reasons for refusal to readmit. Review of an email from R219's Guardian to the Discharge Planner at the BH facility on 11/12/2024 at 4:18 PM, revealed that Guardian Services still planned to have R219 return to the facility when he was ready for discharge. Review of an email from the Supervisor of Guardian Services for the Cabinet for Health and Family Services (CHFS) to the facility's Administrator, dated 11/12/2024, revealed the Supervisor noted concerns about the facility refusing to allow R219 to return. She stated that no Discharge Notice had been issued, and without such notice, R219's rights were violated. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a letter from R219's Guardian to the Secretary of the CHFS, dated 11/18/2024, revealed it was in regard to an appeal of involuntary discharge from the facility and request for a stay of discharge. The letter stated, when the facility sent R219 to the local emergency department (ED) on 11/02/2024, it did not issue a bed hold notice or a discharge notice. Per the letter, the State Guardianship Office was made aware of the transfer only after the local hospital contacted them. The letter stated, on 11/02/2024, the local ED transferred R219 to a Behavioral Health (BH) facility for ongoing treatment. Per the letter, although R219 was ready to be discharged back to the original facility, on 11/11/2024, the BH facility informed the Guardian that the facility declined to readmit him. Further review of the letter revealed that, as of the date of the letter, the facility had not issued a written discharge notice despite being requested to do so, and they [the Guardian] had retained legal counsel to request a stay of discharge. Review of a letter from the Legal Aid Counsel to the facility's Administrator, dated 11/20/2024, revealed she had been retained to represent R219 because the facility wrongfully dumped [R219] at the hospital and refused to readmit him. Review of an email from the facility's Administrator to the Psychiatric Hospital, dated 11/21/2024 at 10:20 AM, revealed the Administrator requested documentation that R219 was not a danger to self or others. Review of an email from the facility's Administrator to R219's Counsel, dated 11/21/2024 at the 11:21 AM, revealed if R219 did not pose a threat to himself or others, the facility would readmit R219. Review of an Order Staying Discharge, dated 11/22/2024 and filed on 11/26/2024, revealed the facility was prohibited from taking any further actions or steps toward discharging R219. According to the Order, the State Guardian, on behalf of R219, claimed the facility took actions to involuntarily discharge R219 without a notice of discharge or notification of bed hold. Review of R219's Face Sheet found in the resident's EMR revealed the facility initially admitted the resident on 09/10/2023 with diagnoses to include dysphagia, schizophrenia, and bipolar disorder. Review of the R219's annual Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 09/18/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of eight of 15, which indicated the resident had moderate cognitive impairment. During an interview with the Business Office Manager (BOM) on 04/22/2025 at 2:25 PM, she stated the nurse was responsible for completing the Transfer/Discharge sheet, which included the reason for transfer or discharge, the facility to which the resident was being transferred, and an explanation of the Bed Hold policy. She stated the white copy was given to the resident to take to the hospital; the yellow copy was kept for the resident's EMR; and the pink copy was provided to the resident's responsible party. She stated the facility would mail the pink copy to the resident's Power of Attorney (POA), Resident Representative (RR), or resident's State Guardian. She stated the notice was sent by regular mail, and the yellow copy would indicate mailed if it had been sent. Additionally, she stated the Ombudsman received last month's transfer/discharge information at the beginning of each month. She stated she gave R219 a copy of the bed hold policy and mailed a copy to the Resident's Guardian. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 04/22/2025 at 2:35 PM, she stated the floor nurse on duty was responsible for notifying the resident, the resident's representative (RR), and/or the guardian about the provider's order for transfer. She stated the resident's representative was informed of the reason for the transfer and the facility to which the resident was being transferred. The DON stated nursing staff was responsible for completing the Transfer/Discharge form, which included the reason for the transfer or discharge, the name of the facility where the resident was being transferred, and an explanation of the Bed Hold policy. The DON stated the nurse must ensure the receiving hospital received a report on the resident, including the reason for the transfer. She stated, while these notifications should occur in a timely manner, they could sometimes be delayed in emergency circumstances. The DON stated the nurse should complete the bed hold/transfer paperwork, which accompanied the resident. She stated one copy of the paperwork was scanned into the resident's chart. Additionally, the DON stated the Business Office followed up with the resident's representative or guardian on the next business day. She stated notification to the RR was important to ensure compliance with the resident's rights. During a telephone interview with R219's Legal Counsel (LC) on 04/24/2025 at 8:36 AM, she stated she was retained by the State Guardian's Office in 11/2024 after R219 was not allowed to return to the facility from the BH facility on 11/11/2024. She stated there was no notice of discharge provided to the Guardian. Furthermore, the LC stated, according to the Guardian, he and the Discharge Planner at the BH facility had difficulty reaching anyone at the facility to discuss the matter. She stated the Guardian was told by the Discharge Planner on 11/11/2024 that the facility would not be readmitting R219. The LC stated on 11/20/2024 she sent the facility's Administrator a letter that she was retained as R219's counsel because the facility dumped R219 at the hospital and refused to readmit him. She stated she also notified the facility's Administrator that she had filed a motion to stay his discharge. During an interview with the Guardian on 04/24/2025 at 9:36 AM, he stated, on 11/02/2024, R219 exhibited a change in condition to include behaviors. He stated the facility sent R219 to the local ED, and R219 was not admitted to that hospital but was sent to a BH facility on the same day. The Guardian stated, on 11/04/2024, R219 was admitted to the local hospital from the BH facility due to having seizures and was discharged back to the BH facility on 11/06/2024. The Guardian stated R219 went from the BH facility to a Psychiatric hospital on [DATE], and finally returned to the facility on [DATE] after a Court Order staying the discharge. The Guardian stated he was informed by the Discharge Planner at the BH facility that the facility would not accept R219 back due to needing a higher level of care and continued behavioral issues. He stated both he and the Discharge Planner would contact the facility regarding R219; however, no one at the facility would return their calls. He stated, We did not receive a bed hold or notice of discharge. Additionally, the Guardian stated the facility did not accept R219 back until the facility was presented with a stay of discharge by R219's counsel. (continued on next page)

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 04/24/2025
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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview with the District LTC Ombudsman on 04/22/2025 at 10:25 AM, she stated R219 was sent to a Behavior Health (BH) facility on 11/02/2024. She stated when the BH facility's Discharge Planner attempted to notify the facility of R219's anticipated discharge, they would not return her calls. The Ombudsman stated the facility did not want to take R219 back because they felt he was not appropriate for the facility due to recent behaviors. She stated the District LTC Ombudsman's office was not notified of the facility's intention to discharge R219 after his transfer to the BH facility in November 2024. She stated the facility did not notify her in writing with a 30-day Notice of Discharge letter, and that was why they had to bring him back to the facility. She stated she notified Legal Aid of the situation when she was made aware. She stated, When there is a non-admit, a discharge appeal is made to legal aid. She stated R219 stayed longer than necessary at the BH facility, ultimately being sent to the State Psychiatric Hospital. The Ombudsman stated the facility had a history of sending off [residents] to the hospital and dumping. She stated the facility did not communicate well with the Ombudsman on necessary matters. She stated she received emails from the facility at the beginning of the next month regarding all prior month's transfer/discharges. During an interview with the facility's Administrator on 04/23/2024 at 11:30 AM, he stated R219 was sent to a BH facility on 11/02/2024, for evaluation, due to his inappropriate outbursts and conduct toward staff. The Administrator stated he did not send a Notice of Transfer/Discharge to R219's Guardian or Ombudsman after the transfer to the BH facility because it was not their intent to refuse to readmit R219. He stated the BH facility transferred R219 to the State Psychiatric Hospital (SPH) on 11/14/2024. He stated upon R219's arrival at the SPH, the facility then required documentation from the physician treating R219 to confirm that he was no longer a danger to himself or others. Furthermore, the Administrator stated the only delay in transferring R219 back to the facility was waiting for the paperwork indicating R219 did not pose a potential harm to himself or others. He stated R219 was admitted back into the facility from the SPH on 11/26/2024. During continued interview with the Administrator on 04/23/2024 at 11:30 AM, he stated R219 exhibited numerous behaviors over his course of stay at the facility that caused over $10,000 in damage to equipment. He stated R219 displayed verbal and physical abuse toward staff. He stated R219 wanted to move to a personal care home, but his appointed State Guardian would not allow it due to R219's health situation, which required a higher level of care and a modified diet. He stated once the facility conducted a modified barium swallow (MBS) study, which R219 passed, he was later able to transition to a lower level of care. The Administrator stated once back from the SPH, and after he passed the MBS study, R219 continued to have outbursts, prompting the facility to provide the resident and his representatives with a 30-day Notice of Transfer/Discharge. He stated R219 was discharged from the facility to a lower level of care in early 2025. During an additional interview with the Administrator on 04/23/2025 at 3:00 PM, he stated, despite R219 being under the care of the facility's in-house psychiatric service, R219 exhibited continued disruptive behaviors, including breaking property and striking a nurse with a pill crusher. He stated these episodes were becoming more frequent and severe. The Administrator stated the facility determined that R219 needed inpatient psychiatric services. He stated the reason for discharge was not related to the resident's clinical or behavioral condition. He stated he was only concerned about R219's potential to endanger himself and the safety of others within the facility. The Administrator stated it was important to follow the facility's policy to ensure compliance related to all transfers and discharges. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace Nursing and Rehabilitation Center	7300 Woodspoint Drive Florence, KY 41042

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Regional [NAME] President (RVP) on 04/23/2025 at 3:00 PM, he stated the facility could address the resident's activities of daily living (ADL) and medical needs. However, they noted the resident would become upset, leading to property destruction. The RVP maintained the reason for discharge was not related to the resident's clinical or behavioral condition. He stated that adhering to the facility's discharge policy was important to remain compliant. During an interview with the Medical Director on 04/24/2025 at 5:36 PM, she stated the facility initiated R219's transfer due to behavioral issues and R219's need for continuous one-on-one care. She stated the facility offered both inpatient and outpatient psychiatric services, and the contracted psychiatric provider had oversight of R219's behavioral health needs. Additionally, she stated the facility would not refuse to readmit R219 because of behavioral concerns. The Medical Director stated the facility had adequate staff to care for R219. She stated she was not consulted about the plans for R219's discharge after he was admitted to the Psychiatric Hospital in 11/2024.