STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395449	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapel Manor	1104 Welsh Road Philadelphia, PA 19115

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. Based on clinical record reviews, interviews with staff, reviews of hospital records and facility policies and procedures, it was determined that the facility failed to permit one of three residents reviewed to return to the facility after hospitalization. (Resident R1) Findings include: Review of the undated policy titled Bed-Hold revealed that when a resident/patient is transferred out of the service location to a hospital or on therapeutic leave, the designee will provide the resident and his/her representative, if applicable with the written Bed Hold Policy& Authorization form regardless or the payer. If the resident representative is not present to receive the notice upon transfer, the notice is delivered via e-mail, fax or hard copy via email. Review of the undated policy titled, Discharge and Transfer revealed that for unplanned acute care transfers for the patient must be permitted to return to the Center. For unplanned, acute transfers for the center to initiate discharge while the patient is in the hospital following transfer, the Center must have evidence that the patient's status at the time the patient seek to the Center (not at the time patient was transferred for acute transfer) meets one of the discharge criteria. Clinical record review for Resident R1 revealed that this resident was admitted from the hospital on January 7, 2025, with diagnoses to include traumatic brain injury, epilepsy (is a brain disorder that causes seizures, which are sudden, uncontrolled bursts of electrical activity in the brain). The nursing note dated February 26, 2025, indicated, that the resident was behaving in a threatening and erratic way towards other residents and staff. Police was called. Resident was transferred to hospital for medical clearance, then transferred to a psychiatric hospital. Social service will provide support as needed. Further review of Resident R1's record revealed that the resident's family member was called and informed the situation that had occurred and to follow up with the hospital and psychiatric hospital for discharge planning. The resident's family member reported that this behavior is usual for resident, and he is not able to care for him. The Social Worker encouraged the resident's family member to find an appropriate placement, where he can get the type of care that he needs. (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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NAME OF PROVIDER OR SUPPLIER Chapel Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1104 Welsh Road Philadelphia, PA 19115	

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the clinical record revealed no documented evidence that the facility assisted the resident or the family in finding an appropriate placement. It was documented that the resident's family member stated he cannot provide support to the resident post discharge which was the facility's discharge disposition for Resident R1. Interview with the Supervisor for the city psychiatric intervention program on March 12, 2025 and 12:00 p.m., revealed that the Psychiatric hospital evaluated the resident during the hospital stay on February 26, 2025, and wanted to discharge him because the physician did not feel he was a threat to himself or others. Interview with admission staff at Psychiatric hospital on March 12, 2025 at 12:05 p.m. revealed that the facility was reached out to discuss the readmission of the resident. Facility stated they could not take the resident back. Facility was informed that the resident was evaluated by the physician and cleared for discharge back to the facility. However facility continued to refuse the resident. Review of clinical record for Resident R1 revealed no documented evidence that the facility assessed the resident or reviewed clinical record for safety at the time the resident was ready for discharge. Interview with Social Service Director on March 12, 2025. revealed the resident was planned to be discharged with the family member however he stated he could not provide care to the resident. There was no safe discharge for the resident available anytime during his stay at the facility. Social Service Director confirmed that the facility should hold resident bed during acute transfers. Interview with the Administrator on March 12, 2025, confirmed that the hospital was not his planned discharge location. Administrator confirmed that when residents were transferred to the emergency room or acute care they were expected to return. 28 PA. Code 201.14(a)(b) Responsibility of licensee 28 PA. Code 201.29(c.3)(4) Resident rights 28 PA. Code 211.12(d)(1) Nursing services

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. Based on the review of clinical records, facility policies, and interview with staff, it was determined that the facility failed to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Facility failed to update a resident's comprehensive care plan and discharge plan, as appropriate for one of three residents reviewed (Resident R1) Findings Include: Review of facility policy Discharge and Transfer: dated November 15, 2022 revealed that The Center must develop and implement an effective discharge planning process that focuses on the patient ' s/resident ' s (hereinafter patient) discharge goals, preparation of patients to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable re-admissions. The Center ' s discharge planning process must be consistent with the patient ' s discharge rights. Refer to Resident Rights Under Federal Law policy. Upon admission, all patients will be asked about their discharge goals and anticipated length of stay, and assessed for discharge potential. Discharge planning will begin upon admission and be completed as part of the Person-Centered Care Plan process. Within 72 hours of admission, evaluation of discharge potential will be reviewed at the Post admission Patient/Family Conference. Interprofessional Utilization Management (UM) and Discharge Planning meeting will be conducted to continue evaluation of discharge potential. All patients being discharged to home, to an assisted living facility, or another community based setting will be given a Discharge Transition Plan and Discharge Packet. The Discharge Transition Plan must include, but not be limited to: · A recapitulation of the patient ' s stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. · A final summary of the patient ' s status at the time of discharge that is available for release to authorized persons and agencies, with the consent of the patient or patient representative. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	· Reconciliation of all pre-discharge medications with the patient ' s post-discharge medications (both prescription and over-the-counter). · A post-discharge plan of care that is developed with the participation of the patient and, with the patient ' s consent, the patient representative(s), which will assist the patient to adjust to his/her new living environment. · Where the patient plans to reside, any arrangements that have been made for the patient ' s follow-up care and any post-discharge medical and non-medical services. The PCC Discharge Plan Documentation UDA will begin as early as admission and no later than seven days prior to patient discharge. Refer to the Guidelines for Discharge Transition Plan Process. 4. Nursing or Social Services: 4.1 Initiates the Discharge Plan Documentation UDA for completion by the interprofessional care team; 4.2 Communicates the discharge date to the patient and/or patient representative; and 4.3 Prepares the patient and/or resident representative for transition. 5. Once the Discharge Plan Documentation UDA is completed, a Discharge Transition Plan will be generated. 6. The Discharge Transition Plan will be reviewed with and given to the patient and/or patient representative along with the Discharge Packet upon discharge. Clinical record review for Resident R1 revealed that this resident was admitted from the hospital on January 7, 2025, with diagnoses to include traumatic brain injury, epilepsy (is a brain disorder that causes seizures, which are sudden, uncontrolled bursts of electrical activity in the brain with medication non-compliance, and altered mental status. Review of care plan for Resident R1 dated January 27, 2025 revealed that the resident had a potential to discharge with interventions included, -Identify, discuss and document resident/patient desires and concerns/barriers, (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Evaluate discharge planning needs taking into consideration care plans, resident/patient goals, cognitive skills, functional mobility and need for assistive devices regarding discharge - Make referrals to community-based agencies, providers, and services communicating the residents/patients needs and barriers to care. Review of progress note dated February 24, 2025 revealed that social service spoke to resident's family member via phone. The family member informed the social worker that he left a list for social service to get resident placed for long term care. Social Service (SS) reminded that resident's discharge is expected on February 26, 2025. Social Services educated the family member that 2 days was not enough time to look into long term placement. Review of progress note dated February 19, 2025, revealed that Social Service spoke to resident's family member to confirm discharge planning address and discuss skilled services referrals. The resident's family member stated that the plan has always been long term care. He shared that he is unable to care for the resident. Social Worker educated brother about nursing facility eligibility and the need to importance of locating appropriate placements. Resident's family memeber was upset stating that he cannot care for resident to assist with home care services. The resident's family member agreed to look continue to look for appropriate settings. Review of Resident R1's clinical records revealed no documented evidence that the facility documented, on a timely based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. There was no documented evidence of a discharge plan with all relevant resident information to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. Further review of Resident R1's clinical record revealed no evidence that the input from resident's family member about long term care and inability to provide support for the resident was taken in to account when resident's discharge planning was initiated. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.10 (a) Resident care policies.