STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395595	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belvedere Center, Genesis Healthcare, The	2507 Chestnut Street Chester, PA 19013

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on a review of the facility's policy, facility documentation, clinical records, and staff interview, it was determined that the facility failed to monitor resident's skin condition and follow wound physician's treatment orders/recommendations resulting in harm to Resident CL1 of discovering the wound at an advanced Stage 3 (full thickness loss of skin that extends into the subcutaneous tissue but does not cross the fascia beneath), wound deterioration, and unnecessary pain/discomfort for one of two residents reviewed (Resident CL1). Findings include: Review of the facility's policy titled Skin Integrity and Wound Management, reviewed May 1, 2024, revealed that nursing assistants will observe skin daily and report any changes or concerns to the nurse. The licensed nurse will evaluate any reported or suspected skin change or wounds and perform daily monitoring of wounds or dressing for the presence of complications or declines. Implement wound care treatments/techniques as indicated and ordered. Review of Resident CL1's diagnosis list includes Dementia (term used to describe a group of symptoms affecting memory, thinking, and social abilities severely enough to interfere with daily life), Urinary Tract Infection (UTI), and Peripheral Vascular Disease (PVD- circulatory condition that causes blood vessels outside the heart and brain to narrow, block, or spasm). Review of Resident CL1's clinical admission assessment revealed resident was admitted to the facility on [DATE]. Further review of admission assessment under section skin assessment revealed the presence of scabs on both lower extremities. Additional review of the clinical admission assessment failed to reveal any skin wounds to the sacral area (tailbone). Review of Resident CL1's Admission Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) dated February 22, 2024, revealed Resident CL1 had severe cognitive impairment. Further review of the admission MDS assessment revealed Resident CL1 was rating as always being incontinent of both bowel and bladder and was dependent on bed mobility. Additonal review of the MDS revealed resident did not have pressure ulcer upon admission and was at risk for developing a pressure ulcer. Review of Braden Scale Assessment (scale used for predicting pressure sore risk) dated March 1, 2024, revealed a score of 14 indicating Resident CL1 was moderately at risk for developing a pressure ulcer. (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: Belvedere Center, Genesis Healthcare, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 2507 Chestnut Street Chester, PA 19013	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident CL1's skin and incontinent care plans revealed interventions including observing skin for signs of skin breakdown (redness, cracking, blistering, decreased sensation, and skin that does not blanche easily), and monitoring for skin redness/irritation and reporting as indicated. Review of Resident CL1's clinical record revealed that weekly skin assessments were conducted but issues with skin integrity were not noted. Review of Resident CL1's nursing progress notes dated March 7, 2024, at 12:24 p.m., revealed a new open area was discovered on Resident CL1's sacrum. Upon further assessment, a new Stage 3 was noted on the sacrum. The wound was assessed, treatment was applied, all parties were notified, the care plan was updated, and a new treatment order was placed. Review of Resident CL1's skin assessment dated [DATE], revealed Resident CL1's sacrum Stage 3 wound was determined to be in-house acquired, measuring 3.3 x 1.7 x 0.1 cm. with light serosanguinous drainage (type of wound drainage that is a combination of blood and serum). Review of Resident CL1's physician orders dated March 7, 2024, revealed a wound treatment to cleanse the wound with wound cleanser, apply Thera honey (wound dressing saturated with Manuka Honey, used to maintain a moist environment conducive to wound healing while permitting the passage of exudate into a secondary dressing), and cover it with foam dressing. Change every other day and as needed if soiled or dislodged. Review of the facility's documentation, including Incident Report dated March 7, 2024, revealed wound nurse was notified of the new Stage 3 wound discovered on the resident's sacrum. The investigation failed to reveal why the resident's sacral wound was discovered at an advanced Stage 3 level. Review of Resident CL1's wound consult report dated March 18, 2024, revealed Resident CL1's sacral wound was a Stage 3 measuring 2.5 x 3.5 x 0.2 cm. with 60% slough (non-viable yellow, tan, gray, green, or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed). The wound order was to cleanse the sacral wound with normal saline and apply Medi honey to the wound cover with border dressing change daily and as needed. Review of Resident CL1's March 2024, Treatment Administration Record (TAR) revealed that the March 18, 2024, treatment recommendation/order of the wound doctor was not followed. Resident CL1's Stage 3 sacral wound was treated every other day instead of daily as ordered by the physician. Review of Resident CL1's wound consult report dated March 24, 2024, revealed Resident CL1's sacral wound continued to be categorized as Stage 3 wound with measurements of 3.2 x 3.5 x 0.5 cm. with 60% slough. The wound recommendation/order was to cleanse the sacral wound with normal saline and apply Medi honey to the wound cover with border dressing change daily and as needed. Review of Resident CL1's March 2024, Treatment Administration Record (TAR) revealed the March 24, 2024, treatment recommendation/order of the wound doctor was not followed. Resident CL1's Stage 3 sacral wound was treated every other day instead of daily as ordered by the physician. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on August 22, 2024 at 11:00 a.m. with the wound nurse, licensed Employee E3 revealed that Employee E3 does wound rounds with the wound doctor on a weekly basis. Employee E3 indicated the attending physicians automatically approve the recommendations of the wound physician. Employee E3 reported that he/she was responsible for reviewing the wound doctor's consult and placing the order. Employee E3 confirmed that the wound doctor's treatment order/recommendation made on March 18, and 24, 2024, was not followed. Review of the wound consult dated April 3, 2024, revealed Resident CL1's sacral wound is now categorized as Unstageable (obscured full-thickness skin and tissue loss) measuring 2.8 x 3.9 x 0.8 cm with 60% slough. The wound treatment order was to cleanse the sacrum with wound cleanser, pack the wound lightly with 1/4 Dakin's moistened gauze, and cover with border dressing daily and as needed. Review of Resident CL1's March and April 2024, TAR revealed from March 18, 2024, until April 4, 2024, Resident CL1's sacral wound was documented as administered/treated on March 20, 21, 22, 26, 28, 30, and April 1, 2024. Review of Resident CL1's wound consult dated April 11, 2024, revealed Resident CL1's sacral wound was categorized as Unstageable with measurements of 4.5 3 x 1 cm. Undermining has been noted at 9:00 and ends at noon with a maximum distance of 1.2 cm. There is a moderate serosanguinous drainage which has a strong odor. 80% eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound). The wound is deteriorating. Review of Resident CL1's physician's notes dated April 11, 2024, revealed resident was examined after evaluation by the wound care team. The sacral wound was worsening with malodorous discharge with concern for Osteomyelitis (Bone infection). A transfer to the hospital was ordered by the physician. Review of Resident CL1'S hospital records revealed that in the ER (emergency room) patient was found to have a mucopurulent (combination of mucous and pus), malodorous sacral wound. The same note revealed that the patient had a sacral wound for about one month that had become progressively painful. The pain was burning, non-radiating, and worse with the pressure shown. MRI (Magnetic Resonance Imaging - medical imaging that uses strong magnetic fields and radio waves to generate images of the organ of the body) revealed early Coccygeal Osteomyelitis. The wound was debrided and washed out by surgery and was placed on IV antibiotics (Intravenous- medications administered in the vein). The above information was discussed with the Nursing Home Administrator on August 22, 2024, at 12 p.m. The facility failed to ensure Resident CL1's skin was appropriately monitored, and the physician's order was followed resulting in a harm of discovering an advanced Stage 3 sacral wound, further wound deterioration, and pain. 28 Pa. Code 211.11(d) Resident care plan Previously cited 7/18/24 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Previously cited 7/18/24 28 Pa. Code 211.10 (d) Resident care policies Previously cited 7/18/24