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Form Approved OMB
No. 0938-0391

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	07/18/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46166 Based on observation and staff interview, it was determined the facility failed to maintain resident dignity for one of one residents (Resident 80). Findings include: Review of Resident 80's Minimum Data Set (MDS, Standardized assessment used to collect information about a resident for quality measure) with a date of completion of May 9, 2024, revealed Resident 80 possesses a BIMS (Brief Interview for Mental Status) of 8 (indicating moderate cognitive impairment). Additional review of Resident 80's MDS revealed under section 8 (Hearing, Speech, and Vision) that Resident 80 has difficulty understanding others and difficulty communicating with others. Review of Resident 80's medical diagnosis revealed an active diagnosis of Other Nontraumatic Intracerebral Hemorrhage (brain bleed caused from a stroke that caused memory loss, difficulty speaking and understanding .). Observations conducted on July 15, 2024, at 9:45 a.m. revealed a sign on Resident 80 [NAME] indicating, Resident 80 FALL RISK. Observations conducted on July 16, 2024, at 10:13 a.m. revealed the sign remained on Resident 80's door. Observations conducted on July 17, 2024, at 8:30 a.m. revealed the sign remained on Resident 80's door. Interview conducted with Nursing Home Administrator (NHA) on July 18, 2024, at 12:15 p.m. reported the facility did not have the consent of Resident 80 or Resident 80's POA (Power of Attorney). The NHA confirmed the facility failed to respect Resident 80's dignity. 28 Pa. Code 201.29 (j) Resident Rights

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47968 Based on clinical record reviews and interviews with staff, it was determined that the facility failed to ensure the advanced directives were accurately reflected in residents' records for one of 30 residents reviewed (Resident 79). Findings include: Review of Resident 79's clinical records revealed that the resident was admitted to the facility on [DATE], and review of clinical record revealed diagnoses including Chronic Kidney Disease, Malignant Neoplasm of Prostate (prostate cancer), Bradycardia (slow heart rate), Cardiac Arrhythmia (irregular heartbeat), Urethral Stricture (narrowing of the urethra), Obstructive and Reflex Uropathy (blockage in urinary tract), Urine Retention, Benign Prostatic Hyperplasia (enlarged prostate), Hypertension (high blood pressure) and Abnormalities of Gait and Mobility (changes in walking pattern). Continued review of Resident 79's clinical record revealed the resident had a BIMS (Brief Interview for Mental Status) scored of five which indicating the resident was severely cognitively impaired. Review of Resident 79's clinical records revealed a care plan dated January 24, 2023, documenting the resident has an established advanced directive of Full Code (life sustaining measures). Further review of Resident 79's clinical records revealed a care plan dated April 12, 2024, documenting the resident was admitted into hospice care due to end stage diagnosis of Senile Degeneration of the Brain, with the goal being the resident will achieve the highest possible level of acceptance and readiness for death by the time of death. Review of Resident 79's active physician orders, revealed an order, dated April 10, 2024, indicated the resident's advanced directive to be Do Not Resuscitate (DNR), Do Not Intubate (DNI), Do Not Hospitalize (DNH). Review of progress notes from April 10, 2024, through July 18, 2024, for Resident 79 revealed no indication as to reason the physician's orders did not match the resident's care plan. Interview conducted on July 18, 2024, at 1:55 p.m. with Director of Nursing confirmed the above information. 28 Pa Code 211.12(d)(3) Nursing services 28 Pa Code 211.12(d)(5) Nursing services

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47968 Based on review of clinical records and staff interviews, it was determined the facility failed to ensure a baseline care plan was developed for one of the 30 residents reviewed (Resident 110). Findings include: Review of Resident 110's clinical record revealed the resident was readmitted to the facility on [DATE], with a diagnosis of Acute Diastolic (Congestive) Heart Failure, Hypertension (high blood pressure), and Absence of Left Leg Above Knee. Review of Resident 110's clinical records revealed physician orders dated July 3, 2024, documenting the following orders: Pulse Oxygen every shift to keep oxygen sats greater than or equal to 90%. Clean external filter on oxygen concentrator. Oxygen tube change weekly, label each component with date and initials. Oxygen at 2L/min via Nasal Cannula, continuously. Review of Resident 110's clinical records revealed a Minimum Data Set (MDS) assessment dated [DATE], documenting the resident required oxygen therapy on admission and while in the facility. Review of Resident 110's care plan failed to reveal that a baseline care plan was developed for the resident receiving oxygen. The facility failed to ensure Resident 110's baseline care plan for oxygen was developed. Interview conducted with the Director of Nursing on July 18, 2024, at 1:55 p.m. when the above findings were reviewed. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(5) Nursing Services 28 Pa Code: 211.10(c) Resident care policies

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37789 Based on clinical record review, it was determined that the facility failed to ensure residents had comprehensive care plans for one of 26 residents reviewed (Resident 113). Findings include: Review of Resident 113's admission elopement assessment dated [DATE], revealed the resident scored a 6, indicating the resident was an elopement risk. Review of Resident 113's elopement assessment dated [DATE], revealed the resident scored a 1, indicating the resident was an elopement risk. Review of Resident 113's care plan failed to reveal a plan of care addressing the resident's risk for elopement. The above findings were discussed with and confirmed with the Director of Nursing on July 18, 2024, at 10:05 a.m. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37789

Based on clinical record review and facility documentation, it was determined the facility failed to ensure one of two residents reviewed for elopement was provided adequate supervision to prevent elopement (Resident 113).

Findings include:

Review of Resident 113's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, altered mental status, Schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), and homelessness.

Review of Resident 113's admission Minimum Data Set (MDS - periodic assessment of resident care needs) dated April 8, 2024, revealed the resident had a BIMS score of 15, indicating the resident had no cognitive impairment at the time of admission.

Review of Resident 113's quarterly MDS dated [DATE], revealed the resident had a BIMS score of 12, indicating mild cognitive impairment.

Review of Resident 113's clinical record revealed the resident signed a transportation agreement on April 5, 2024, which stated that the facility does not provide staff escorts for appointments.

Review of Resident 113's admission elopement assessment dated [DATE], revealed the resident scored a 6, indicating the resident was an elopement risk.

Review of Resident 113's elopement assessment dated [DATE], revealed the resident scored a 1, indicating the resident was an elopement risk.

Review of Resident 113's progress notes revealed a nurse's note on June 17, 2024, revealed Resident out to Vascular appointment. Per [physician] appointment needs to be rescheduled with family present to make decisions concerning below knee amputation.

Further review of Resident 113's progress notes revealed a care plan meeting note dated June 19, 2024, which stated that the resident's Power of Attorney stated that she could escort Resident

to her medical appointments.

Interview with the Director of Nursing on July 15, 2024, at approximately 11:00 a.m. revealed Resident 113's appointment was scheduled for 10:30 a.m. on July 9, 2024.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of information submitted by the facility revealed on July 9, 2024, at 11:00 a.m., the facility received a call from the vascular surgery center that Resident 113 left the building after checking in at 10:15 a.m. The resident's Power of Attorney arrived at the appointment at 10:22 a.m. Review of the witness statement from the transport driver revealed the driver witnessed the resident walking down the street. The above findings were discussed with the Director of Nursing on July 19, 2024, at 10:05 a.m. 28 Pa. Code 211.11(d) Resident care plan 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 30934 Based on clinical record review and staff interview it was determined the facility failed to provide care and services related to catheter care for one of five residents reviewed. (Resident 90) Findings Include: Review of Resident 90's physician orders revealed an order dated January 16, 2024 to perform indwelling catheter care every day and night shift. The physician's order was discontinued on April 17, 2024. Observation of Resident 90 on July 15, 2024 at 9:30 a.m. revealed Resident 90 had an indwelling catheter. Review of resident 90's clinical record revealed there was no documented evidence Resident 90 had been receiving catheter care since April 17, 2024 when the order for care was discontinued. Interview with the Director of Nursing on July 18, 2024 at 11:30 a.m. confirmed Resident 90 had an indwelling catheter and there was no documented evidence they had received care since April 17, 2024. 28 Pa. Code 211.5 (f) Clinical record 28 Pa. Code 211.10 (d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(3) Nursing services