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	08/15/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Number of residents sampled: Number of residents cited: Based upon observation, it was determined the facility failed to ensure medications were properly labeled with open and expiration dates for three of four medication carts observed (North Back Hall Cart, North Front Cart and South Middle Cart).Findings include:Review of package insert instructions for Humalog (Lispro) Insulin Pens revealed unopened Humalog pens should be stored in the refrigerator.Further review of package insert instructions for Humalog Insulin Pens revealed that once opened, Humalog can be kept at room temperature for up to 28 days. Review of package insert instruction for Lantus Insulin revealed Lantus Insulin should be used within 28 days after opening. Review of package insert instruction for Lantus (glargine) Insulin revealed Lantus Insulin should be used within 28 days after opening.Observation of the North Back Hall Medication Cart on August 15, 2025, at 9:12 a.m. revealed one open Lispro Insulin Pen with no open or expiration date; three open Lantus Insulin Pens with no open or expiration date; one unopened and unrefrigerated Lispro Insulin Pen; two open Humalog Insulin Pens with no open or expiration date; one Glargine Insulin Pen with no resident name, no open or expiration date; and one unopened Glargine Insulin Pen unrefrigerated.Observation of the North Front Hall Medication Cart on August 15, 2025, at 9:16 a.m. revealed one unopened Lantus Insulin Pen unrefrigerated.Observation of the South Hall Middle Medication Cart on August 15, 2025, at 9:21 a.m. revealed one open Lantus Insulin Pen with no open or expiration date; one open Basaglar Insulin Pen with no expiration date and one unopened Humalog Insulin Pen unrefrigerated.The above information was conveyed to the Director of Nursing on August 15, 2025, at 11:00 a.m. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing ServicesPreviously cited 7/18/2024, 8/23/2024

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of a transfer to the hospital for 1 of 26 residents reviewed (Resident 134). Findings include: Review of facility records revealed a policy titled Discharge and Transfer dated June 11, 2025, noting for patients transferred to a hospital for unplanned, acute transfers, the patient must be permitted to return to the facility. Prior to the transfer, the patient and patient representative will be notified verbally followed by written notification using the Notice of Hospital Transfer or state specific transfer form. Copies of notices for emergency transfers must also be sent to the Ombudsman, but they may be sent when practicable, such as in a list of patients on a monthly basis or per state requirement. A review of Resident 134's clinical record revealed the resident was transferred to the hospital on July 21, 2025, due to change of condition and decline in activities of daily living. There was no documented evidence to indicate that the facility provided a written notice to the Office of the State Long-Term Care Ombudsman regarding the resident's hospitalization. Review of the facility's discharge log for July 1, 2025, thru July 31, 2025, revealed Resident 134 was not listed as discharging to the hospital on July 21, 2025. Interview on August 15, 2025, at 2:25 p.m. with Nursing Home Administrator (NHA) and Director of Nursing (DON) when the above was presented the DON confirmed there was no documentation of the Ombudsman's Office being notified of the resident's hospital transfer. 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on clinical record review and interview with staff, it was determined that the facility failed to complete a comprehensive assessment within 14 days after a significant change in the resident's condition for one of 26 residents reviewed (Resident 90).Findings include:Review of Resident 90's physician's orders revealed an order on June 19, 2025, for Compassus Hospice for evaluation and treatment. Review of the resident's progress note of June 20, 2025, revealed resident assessed by Compassus Hospice and has been admitted to their services. Further review of clinical record revealed that a significant change MDS (Minimum Data Set - periodic assessment of resident needs) was completed on June 20, 2025; however, Section O0110 - Special Treatments, Procedures, and Programs indicated that the resident was not receiving hospice care. Review of Resident 90's progress note of June 23, 2025, revealed that Compassus Hospice nurse stated that resident's admission on [DATE], was voided and resident was admitted to hospice on June 23, 2025. Further review of the clinical record revealed a significant change MDS had not been completed after the resident was admitted to hospice.Interview with licensed staff Employee E3 on August 15, 2025, at 12:10 p.m. revealed that hospice was voided on June 20, 2025, because hospice could not admit the resident until seen face to face. Employee E3 also confirmed that hospice started on June 23, 2025, and that a significant change MDS had not been completed. 28 Pa. Code: 211.12(d)(3) Nursing servicesPreviously cited 7/18/24

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure accurate assessments for two of 26 residents reviewed (Residents 95 and 113).Based on clinical record review and staff interview, it was determined that the facility failed to ensure accurate assessments for two of 26 residents reviewed (Residents 95 and 113). Findings include: Review of Resident 95's clinical record revealed the resident was receiving dialysis. Review of Resident 95's quarterly MDS assessment (MDS - periodic assessment of resident care needs) dated July 3, 2025, Section O0110 – Special Treatments, Procedures, and Programs indicated that the resident was not receiving dialysis. Interview with licensed staff Employee E3 on August 15, 2025, at 11:50 a.m. confirmed Resident 95 was receiving dialysis and the resident's MDS was coded incorrectly. Review of Resident 113's clinical record revealed the resident was receiving hospice care. Review of Resident 113's admissions MDS assessment dated [DATE], Section O0110 – Special Treatments, Procedures, and Programs indicated that the resident was not receiving hospice care. Interview with licensed staff Employee E3 on August 15, 2025, at 2:25 p.m. confirmed Resident 113 was receiving hospice care and the resident's MDS was coded incorrectly. 28 Pa. Code: 211.12(d)(1)(5) Nursing services Previously cited 7/18/24

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Number of residents sampled: Number of residents cited: Based on policy review, and clinical records review, it was determined that the facility failed to follow physician orders regarding administration of medications for one of 26 resident (Resident 3) Findings include: Review of medication administration general guidelines section 7.1 dated 01/25-page three of six Medication Administration section 1. Medications are administered in accordance with written orders of the prescriber. Review of Resident 3's clinical record revealed there was a current physician's order for the resident to be receiving Midodrine HCl Oral Tablet 10 MG (Midodrine HCl) (Midodrine is used to treat low blood pressure), Give 1 tablet via PEG-Tube (Peg tube A percutaneous endoscopic gastrostomy (PEG) is a surgery to place a feeding tube. Feeding tubes, or PEG tubes, allow you to receive nutrition through your stomach.) three times a day for Hypotension Hold for SBP (Systolic blood pressure also known as SBP is the top number in a blood pressure reading, indicating the pressure in your arteries when your heart beats. It is measured in millimeters of mercury (mm Hg) and is crucial for assessing cardiovascular health.) Greater than or equal to130.Review of Resident 3's Medication administration record revealed that Midodrine was administered 11 times in the month of June 2025 outside of parameters with a systolic blood pressure greater than/equal to 130. Review of the Medication administration record revealed that Midodrine was administered 9 times outside of parameters in July 2025 with a systolic blood pressure greater than/equal to 130.Informed health care administrator of deficient practices on August 15, 2025, at 1:44 PM. PA Code 211.10(c) Resident Care PoliciesPreviously cited 7/18 2024 PA code S 211.9(a)(1) Pharmacy Services Pa code S 211.12(d)(5) Nursing servicesPreviously cited 7/18 2024

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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. Number of residents sampled: Number of residents cited: Based upon observation, it was determined that the facility failed to ensure medication carts were locked when a staff member was not in attendance for one of four medication carts observed (North Hall Front Cart).Findings include:Observation on August 15, 2025, at 9:16 a.m. revealed the North Hall Front Medication Cart to be open and unlocked with no staff members in attendance. Four residents were observed in the hallway at the time of the observation.During the observation, the cart was able to be opened, and medications were able to be viewed and examined by a surveyor. Licensed employee was observed in a resident room with employee's back to the cart and not able to observe the cart that was left unattended and unlocked.The above information was conveyed to the Director of Nursing on August 15, 2025, at 11:00 a.m. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing ServicesPreviously cited 7/18/2024, 8/23/2024