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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395628 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Renaissance Healthcare & Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 4712 Chester Avenue Philadelphia, PA 19143 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on review of clinical records, review of facility policy, review of facility investigation reports, hospital record review, and staff interviews, it was determined that the facility failed to ensure that one of three residents (Resident R1) reviewed was free from physical abuse and neglect which resulted in actual harm to Resident R1 who sustained a head injury, hematoma to the right side of the face, lip laceration and required transfer to the hospital. This deficiency was identified as past non-compliance. (Resident R1)</p> <p>Findings Include:</p> <p>A review of the facility policy, titled Lifting Machine, Using a Mechanical, dated July 2017 stated, the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device.</p> <p>General Guidelines: at least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. 1. Mechanical lifts may be used for tasks that require: 2. Lifting a resident from the floor; a. Transferring a resident from bed to chair; c. Lateral transfers; d Lifting limbs; Toileting or bathing; or f. Repositioning. Lift design and operation vary across manufacturers. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility.</p> <p>Review of Resident R1's clinical record revealed that the resident was admitted to the facility, with diagnoses that included osteoarthritis of knee (a degenerative joint disease, in which the tissues in the joint break down over time), hammer toes (a foot condition in which the toe has an abnormal bend in the middle joint) right and left foot and muscle weakness.</p> <p>A review of Resident R1's quarterly Minimum Data Set (MDS-a periodic review of a resident's assessment and care needs), dated May 3, 2024, revealed that Resident R1 was dependent on staff for transfer to move between surfaces including to and from bed, chair, wheelchair or the assistance of 2 or more helpers is required for the resident to complete the activity.</p> <p>A review of Resident 1's current care plan dated May 11, 2018, revealed that Resident R1 had the potential for falls related to deconditioning, decreased mobility, and history of falls. The care plan intervention included Resident R1 transfers via a Hoyer lift (allow a person to be lifted and transferred with a minimum of physical effort) with 2 persons assist.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>A review of Resident R1's physician order summary on October 10, 2019, revealed an order to transfer with a Hoyer lift with 2 person assist.</p> <p>A review of the facility investigation for June 4, 2024, revealed Resident R1 was found with facial injuries which included swelling to the resident's right jaw, right forehead and some bleeding was noted to the resident's lip/mouth. New order received to send the resident to the emergency room for evaluation.</p> <p>Further review of the facility investigation revealed that on June 4, 2024, around 7:00 p.m., Employee E3, Nurse aide was taking Resident R1 to her room to put her to bed. According to the employee, she transferred Resident R1 to her bed by herself. According to Nurse aide, Employee E3, due to the resident being very combative and swinging the bed control remote, she left the resident in bed and closed the door. A few moments later, resident was heard screaming by Nurse aide, Employee E4, Help me. Help me. They're beating me up.' Upon entry into the residents' room, Employee E4 observed facial injuries to Resident R1. Employee E4 then got the Charge nurse, Employee E5, who also noticed the injuries. Charge nurse, Employee E5 then informed the Employee E6, Supervisor. Resident R1 had a lump on her forehead, swelling to the right lower jaw, and blood on her lips. Resident was sent to the hospital as ordered by the physician.</p> <p>Review of a statement by the Charge nurse, Employee E5 dated June 4, 2024, revealed that while he was passing out the medication he saw one of the aides taking Resident R1 to her room. When he approached Resident R1's room from a distance he saw the aide struggling with the resident. He asked the aide what was going on and the aide stated the resident was trying to hit her. He advised the aide to leave the resident alone since she was already in the bed. Fifteen minutes later another aide called the nurse to Resident R1's room immediately. When he entered the resident's room he saw a lump on her forehead, swollen right jaw and bleeding from mouth. Resident was in pain.</p> <p>Facility investigation also revealed an interview with Nurse aide, Employee E3 which indicated Upon interview of [Employee E3], she stated that she was taking [Resident R1] to her room. Upon entering the room, [Nurse aide, Employee E3] rolled resident's wheelchair to bedside. [Nurse aide, Employee E3], by herself then picked up the resident from the wheelchair and placed her on the bed, sideways. Once the resident was in bed, [Nurse aide, Employee E3] stated that she then tried to change the resident, but the resident was swinging the bed control remote. [Nurse aide, Employee E3] said she left the residents room due to her being combative and closed the door. [Nurse aide, Employee E3] admitted that she did not use a Hoyer lift (mechanical lift) or have another staff member present during the transfer which was part of the resident's care plan. [Nurse aide, Employee E3] denies hitting the resident and said the injuries were caused by the resident swinging the bed remote</p> <p>Continued review of the investigation revealed that Charge nurse, Employee E5 did not see Resident R1 swinging the bed remote at any time this shift. There was no evidence in the clinical record that the resident had the injuries prior to Resident R1 was transferred to the bed. Staff statement revealed that the resident had no injuries to the face prior to the transfer to the bed.</p> <p>Review of a statement by Nurse aide, Employee E3 dated June 4, 2024, revealed that the resident was in the bed. She was yelling and holding on to the bed remote and swinging it, so she left the room. Continued review of the statement revealed no evidence that Nurse aide, Employee E3 saw Resident R1 hitting herself with the remote.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Nurse aide, Employee E3 was suspended by the facility and did not allow an interview when called over the phone or returned the message left by the State Agency. Review of facility investigation revealed that several attempts were made to contact Nurse aide, Employee E3 to complete a formal statement. Nurse aide, Employee E3 did not respond to any of the attempts.</p> <p>Review of the conclusion of the facility investigation revealed that based on interviews, there was no definitive way to determine how resident sustained her injuries. It was unlikely that the injuries were sustained by the resident swinging the bed control remote. What was known was that by Employee E3's own admission, she did an inappropriate transfer and did not follow the resident plan of care that required two-person transfer with a Hoyer lift. Due to this fact, Employee E3's employment has been terminated.</p> <p>Review of clinical record and resident's care plan did not reveal any evidence that the resident had any behaviors of self-harm such as swinging the bed remote and hurting herself.</p> <p>Interview with Unit manager, Employee E7, on June 27, 2024, at 12:00 p.m. stated most days, she was with her doll baby, she was mostly quiet, she sometimes screams, and throw stuff like water or milk at others. She never hurt anyone or never hurt herself.</p> <p>Interview with Licensed Practical Nurse, Employee E8, on June 27, 2024, at 10:39 a.m. stated she heard someone transferred the resident incorrectly, her lips were swollen, bruise on face under eye, bruise on her head, sometimes she the resident was combative, but never seen her hurting herself. Licensed Practical Nurse, Employee E8 stated the resident was able to make her needs known. Resident was always transferred using a Hoyer.</p> <p>A review of hospital records for Resident 1 dated June 4, 2024, revealed that a [AGE] year-old female with history of osteoarthritis of bilateral knees and unable to ambulate, dementia was sent from nursing home with head injury and questionable assault. Clinical Impression included head injury, Hematoma and lip laceration.</p> <p>An interview with the Director of Nursing and Administrator on June 27, 2024, at 1:00 p.m., confirmed that Nurse aide, Employee E3 did not follow Resident R1's care plan for transfers. Resident R1 was subsequently found with injuries possibly obtained during transfers.</p> <p>This deficiency was cited as past non-compliance.</p> <p>Review of facility Action plan/Follow up documentation revealed the following:</p> <p>The facility was investigating an allegation of Abuse/Neglect that occurred on 6/4/2024 with Resident R1. The resident was seen in the emergency room and returned to the facility.</p> <p>The residents who Nurse aide, Employee E3, had taken care of on the evening of 6/4/24 were evaluated by the Nursing Supervisor on 6/4/24 and were found without injuries.</p> <p>Employee E3 involved in the incident did violate the care plan/Kardex as the resident is a two person Hoyer lift transfer which was also noted on the care plan/Kardex.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Current residents in the facility have had their care plan/Kardex reviewed to ensure that the appropriate transfer status is indicated.</p> <p>All current staff are being re-in serviced by the Director of Staff Development, or designee, regarding the Abuse Prevention Policy.</p> <p>Current RN, LPN and Nurse Aide (N.A). staff are being re-in serviced by the Director of Staff Development, or designee, regarding resident transfers and the need to check the resident's care plan/Kardex for the resident's transfer status prior to performing a transfer. Current RN, LPN and N.A staff are being re-in serviced by the Director of Staff Development, or designee, regarding dealing with combative residents and the need to stop and ensure resident safety, report the behavior to the charge nurse and re-approach the resident at a later time.</p> <p>Re-in servicing has been completed as of 6/7/24 and the facility has determined compliance as of 3 pm</p> <p>Auditing- The Director of Nursing or designee, will audit the RN, LPN and N.A. randomly as they transfer residents to ensure that resident transfers are being performed as indicated on the residents' care plan/Kardex. Audits will be completed weekly x 4 weeks and then monthly for 90 days. Results of the audits will be forwarded to the QAPI Committee for review and additional recommendations.</p> <p>The Director of Nursing, or designee, will randomly audit the resident care plan/kardexes to ensure that appropriate transfer status is indicated.</p> <p>The Social Services Department will conduct random audits to rule out Abuse/Neglect via visits with the residents to ensure there are no Abuse/Neglect concerns weekly x 4 weeks and then monthly. Results of the audits will be forwarded to the QAPI Committee for additional review/recommendations.</p> <p>The facility alleged compliance with their plan of correction as of June 7, 2024.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 201.20(b)(1) Staff Development.</p> <p>28 Pa. Code 201.29(a) Resident rights.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies.</p> | | |