

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  10/03/2024
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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<p>F 0572</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents a notice of rights, rules, services and charges.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47975</b></p> <p>Based on review clinical records, review of facility documentation, and interviews with staff, it was determined that the facility failed to inform residents of their rights, rules, regulations, and responsibilities prior to and/or upon the resident's admission for three out of twenty-three residents reviewed. (Residents R29, R74, R317)</p> <p>Findings Include:</p> <p>Resident Council held on October 2, 2024 at 10:00 a.m. with ten awake, alert, and oriented residents revealed that when asked about resident rights being reviewed there were 1 residents stated they have not received a copy or had a copy reviewed with them.</p> <p>Review of Resident R29's clinical record revealed the resident was admitted on [DATE] and the resident's admission packet was not reviewed with the resident until August 21, 2024.</p> <p>Interview held with Admissions staff, Employee E3 on October 3, 2024 at 12:20 p.m. revealed Resident R29 was admitted on a Friday, and that she does not recall why the admission paperwork was not signed on that Friday. Employee E3 admitted she needed to go back the following week and must have not done so on Monday or Tuesday.</p> <p>Review of Resident R74's clinical record revealed the resident was admitted on [DATE]. Further review of the resident's record revealed the resident's admission packet was not reviewed with the resident's representative until January 19, 2023.</p> <p>Interview held with Admissions staff, Employee E3 on October 3, 2024 at 12:20 p.m. revealed she was not employed here when the paperwork was signed, she only started in May 2024.</p> <p>Review of Resident R317's clinical record revealed the resident was admitted to the facility on [DATE]. Further review of the resident's clinical record revealed the resident's admission packet was not reviewed with the resident until October 1, 2024.</p> <p>Interview with Admissions staff, Employee E3 on October 3, 2024 at 12:20 p.m. revealed she was unsure of why the admissions packet was not completed timely. Employee E3 stated that having the admission paperwork signed timely is something that needs to be worked on.</p> <p>28 Pa. Code 201.29 (e) Resident rights</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0575</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency.</p> <p>47975</p> <p>Based on observations and interview with staff, it was determined that the facility failed to post contact information for the Pennsylvania Department of Health and the Office of the State Long-Term Care Ombudsman program as required for two of four nursing units that was accessible to residents and their representatives. (First floor and Second Floor)</p> <p>Findings Include:</p> <p>On October 1, 2024 at 11:00 a.m. a facility tour was conducted with the Director of Social Services Employee E7 to observe where the Pennsylvania Department of Health and the Office of the State Long-Term Care Ombudsman program postings were on the first floor and second floor units.</p> <p>Observation during the tour of the first-floor unit revealed there was no information posted as required for the Office of the State Long-Term Care Ombudsman.</p> <p>Observation during the tour of the second-floor unit revealed there was no Pennsylvania Department of Health or Office of the State Long-Term Care Ombudsman information posted as required. These findings were confirmed by Employee E7 the Director of Social Services.</p> <p>28 Pa. Code: 201.14(a)Responsibility of licensee</p> <p>28 Pa. Code: 201.18(e) Management</p>		

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<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>47975</p> <p>Based on observation and an interview with staff, it was determined that the facility failed to ensure that the most recent Department of Health Survey results were in a place readily accessible to residents and visitors for two or two nursing units. (First floor and Second Floor)</p> <p>Findings Include:</p> <p>On October 1, 2024 at 11:00 a.m. a facility tour was conducted with the Director of Social Services Employee E7 to observe where the Department of Health Survey binder was located in the facility.</p> <p>Observation of the facilities front lobby revealed the Department of Health survey results binder was behind the desk in the main lobby not accessible for residents or visitors without having to ask. Review of binder revealed the information in the binder also was not up to date. The last results in the binder were from the annual survey dated March 11, 2022. The Director of Social Services Employee E 7 confirmed that this was the only location in the facility where the survey results were available.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(a) Management</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>47975</p> <p>Based on review of facility policy, observation, and interviews with residents and staff, it was determined that the facility failed to ensure that residents and/or their representatives could file a grievance/concern anonymously by failing to ensure that grievance or complaint forms were available to residents or their representatives without asking for two of two units reviewed. (First floor and Second floor)</p> <p>Findings include:</p> <p>Review of the facility policy titled, Grievances/Complaints, Filing with a revision date of April 2017 states, Policy Statement- Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the State Ombudsman).</p> <p>Further review of the facility policy revealed, Policy Interpretation and Implementation .5. Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously. 13. If the grievance was filed anonymously, the grievance officer will inform the resident that a grievance has been anonymously filed on his or her behalf and the steps will be taken to investigate that grievance(s) and report the findings. The grievance officer will reiterate to the resident that it is against facility policy and federal regulations to discriminate or sanction a resident who has filed or verbalized a complaint against the facility, and that his or her rights to be free of discrimination or reprisal will be protected.</p> <p>On October 1, 2024 at 11:00 a.m. a facility tour was conducted with the Director of Social Services, Employee E7 to observe where grievance forms and grievance boxes were located on the first floor and second floor units. The tour of the first and second floor revealed there were no forms readily accessible for residents or their representatives available without having to ask. Further observation revealed there was no locked grievance box available on the first floor or second floor units allowing for residents or their representatives to turn in grievance forms anonymously.</p> <p>On October 1, 2024 at 11:05 a.m. an interview held with the Director of Social Services Employee E7 revealed the only place that grievances form were located was currently in the social services office. Employee E7 stated that if a resident or resident's representative has a concern or a grievance, they have to come to her for her to fill out and file a grievance for them. Employee E7 confirmed there are no grievance forms readily accessible and there is currently no way for the grievance forms to be turned in anonymously.</p> <p>Resident Council held on October 2, 2024 at 10:00 a.m. with ten awake, alert, and oriented residents. When asked about grievance forms five out of ten of the residents (R97, R74, R3, R29, and R72) stated they were not aware of where to access grievance forms in the facility.</p> <p>28 Pa code 201.18(b)(2)(3) Management</p> <p>28 Pa code 201.29(a) Resident rights</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>29720</p> <p>Based on clinical record reviews and interviews with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers and discharges for nine of nine months reviewed (January, February, March, April, May, June, July, August, and September).</p> <p>Findings include:</p> <p>The facility was asked for evidence that the facility was notifying the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers and discharges for the last six months including the months of April, May, June, July, August, and September, 2024.</p> <p>On October 3, 2024 1 at 1:11 a.m. the Nursing Home Administrator, Employee E1 stated that there was no evidence of the transfers and discharges being sent to the Office of the State Long-Term Care Ombudsman due to the social worker being new to the facility. Employee E1 was asked to provide evidence that the notices were sent during the month of January, February, and March, 2024. Employee E1, the Nursing Home Administrator was not able to provide these notices.</p> <p>Resident R11 was transferred to the hospital and admitted with a diagnosis of pneumonia on May 15, 2024. An interview on October 3, 2024 at 11:10 a.m. with Employee E1, Nursing Home Administrator, confirmed that no ombudsman notification was available for review.</p> <p>Resident R8 was transferred to the hospital on December 18, 2024 and admitted through December 21, 2023. An interview on October 3, 2024 at 11:10 a.m. with Employee E1, Nursing Home Administrator, confirmed that no ombudsman notification was available for review.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(2) Management</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47975</b></p> <p>Based on review of facility documentation, observation, review of clinical records, and interview with staff, it was determined that the facility failed to ensure feeding assistance was provided for one of twenty-three residents reviewed. (Resident R80)</p> <p>Findings Include:</p> <p>Review of facility documentation titled, Facility Food Service Program states, Policy and Procedure: Red/Yellow Program- the facility has developed a program to identify residents more easily at mealtime who are at nutritional risk and is in need of supervision, partial assist, or extensive feeding assistance during mealtimes. The following outlines the procedure for flagging those residents. 1. The residents on the list will receive a RED sticker or YELLOW sticker on their meal tags in addition to their usual white napkin. Red Program-Extensive Feeding assistance.</p> <p>Observation of Resident R80 during the lunch meal on September 30, 2024 at 12:53 p.m. revealed the resident was seated in the dining room with two other residents at her table. During the lunch meal observation Resident R80 was observed eating a Styrofoam cup of chocolate pudding. Resident R80 was only using her right arm and hand to feed herself. When asked if the resident enjoyed her lunch she stated, I only ate the chocolate pudding, I do not know what my puree food is and I never eat it. Review of Resident R80's meal ticket revealed the resident's ticket had the regular meal on her ticket for lunch which included bruschetta chicken, garlic green beans, and parmesan noodles.</p> <p>Observation of the food on the Styrofoam plate revealed the puree meal appeared to consist of mashed potatoes, pureed carrots, and pureed chicken. During the lunch meal none of the staff in the dining room provided the resident with feeding assistance at any time.</p> <p>Review of Resident R80's clinical record revealed the resident was admitted to the facility on [DATE]. Review of the resident's record revealed a diagnosis of Aphasia following cerebral infraction dated July 19, 2024. The resident also has a diagnosis of Muscle Weakness with a date of February 22, 2022.</p> <p>Review of Resident R80's clinical record revealed the resident was seen on August 16, 2024 for a modified barium swallow study. Review of the swallow study results revealed a recommendation for a puree diet with thin liquids. Also recommended for the resident to be sitting upright during meals, eat at a slow rate, take small bites/sips, and having 1:1 feeding assistance.</p> <p>Review of Resident R80's clinical record revealed two physician's orders including; Ensure resident has her chin [NAME] when consuming liquids- dated August 16, 2024, Resident is a 1:1 feed and should be sitting upright with meals- dated August 16, 2024, and RED NAPKIN- dated August 16, 2024.</p> <p>Review of facility documentation titled 1st Floor Red Program provided by the Director of Nursing Employee E2 did not include Resident R80 in the list of resident's needing extensive assistance for feeding.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview held with Licensed nurse, Employee E5 on October 2, 2024 at 12:24 p.m. The licensed nurse was asked what red napkin meant when displayed in the physician's orders or on the resident's ticket. The licensed nurse Employee E5 said she was not one-hundred percent sure what is meant but she would guess that it was a label for residents who have trouble utilizing one arm to eat during mealtimes.</p> <p>28 Pa. Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(3) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47975</b></p> <p>Based on observation, review of facility policy, review of clinical records, and interviews with residents and staff, it was determined that the facility failed to ensure appropriate orders, care plan, and maintenance related to respiratory care were in place for one of twenty-three resident's reviewed. (Resident R83).</p> <p>Findings Include:</p> <p>Review of facility policy titled, CPAP/BiPAP Support with a revision date of March 2015 states, Purpose- 1. To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen. 2. To improve arterial oxygenation (PaO2) in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. 3. To promote resident comfort and safety.</p> <p>Observation on September 30, 2024 at 10:30 a.m. of Resident R83 in their room revealed the resident had a CPAP machine bedside. Interview held with Resident R83 revealed the resident stated that the machine was a non-invasive CPAP machine that she had brought from home with her to the facility. Resident R83 stated that she wears it every night and during naps when she is asleep. Further observation of the CPAP machine revealed the water tank was very cloudy with the water currently in it was a light brown color. When asked regarding maintenance and the color of the water Resident R83 stated that the tank needed to be cleaned and the water needed to be changed.</p> <p>Review of Resident R83's clinical record revealed the resident was admitted to the facility on [DATE] with the diagnosis of Respiratory Failure and Obstructive Sleep Apnea.</p> <p>Review of Resident R83's clinical record revealed the resident currently had no order, no care plan, and no maintenance log related to the CPAP machine.</p> <p>Interview with the licensed nurse Employee E5 on October 2, 2024, at 12:25 p.m. confirmed there were no current orders, care plan, or maintenance log related to Resident R83's CPAP machine. Observation of Resident R83's CPAP machine with the licensed nurse Employee E5 confirmed the CPAP water tank was very cloudy and was light brown in color. Employee E5 stated that the water should be changed daily, and the water tank should have a cleaning schedule, or a new tank should be ordered for Resident R83.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12 (d)(3) Nursing Services</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882</b></p> <p>Based on clinical record review and interviews with staff, it was determined that the facility did not ensure that a physician assessment was completed related to unplanned weight loss for one of 23 residents reviewed (Resident R21).</p> <p>Findings include:</p> <p>Review of clinical documentation for Resident R21 revealed that she was admitted to the facility on [DATE], and had diagnoses of , dementia, diverticulitis of the large intestine (a condition wherein abnormal pouches which protrude off of the intestine, known as diverticulum, become inflamed, causing pain and disruption of normal bowel function), and type 2 diabetes.</p> <p>Review of the resident's weight documentation revealed that on August 9, 2024, the resident weighed 225 pounds and on September 20, 2024, the resident weighed 199 pounds. This was an 11.56 % weight loss in less than three months, which met the criteria of a significant weight loss.</p> <p>Continued review of her clinical documentation revealed a Nutrition Evaluation from the Registered Dietitian, Employee E11, dated September 23, 2024. Review of physician progress notes from September 27 and October 1, 2024, revealed no mention of the resident's recent weight loss. No evaluation by the physician in order to address the potential medical causes for the significant weight change noted.</p> <p>Interview with the Nursing Home Administrator, Employee E1 and the Director of Nursing, Employee E2, on October 3, 2024, at 2:30 p.m. confirmed the resident's significant weight change. They confirmed that the physician had not documented an assessment of the potential medical causes of Resident R21's weight loss.</p> <p>28 Pa. Code: 211.12(d)(5) Nursing services.</p> <p>28 Pa. Code: 211.2(a) Physician services.</p> <p>28 Pa. Code: 211.5(f) Clinical records</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882</b></p> <p>Based on observation, clinical record review, and interviews with staff and residents, it was determined that the facility did not ensure that dietary preferences were honored for three of 23 residents (Residents R72, R97, R65).</p> <p>Findings include:</p> <p>During a group interview on October 2, 2024, at 10:00 a.m., Resident R97 stated that he had told facility staff multiple times that he did not like ravioli or egg salad, but that they kept serving those items to him. During this same interview, Resident R72 stated that he was on a no-salt diet, but that the food they served him was too salty.</p> <p>Review of clinical documentation revealed that Resident R72 was admitted to the facility on [DATE]. Review of his most recent MDS (a periodic assessment of resident care needs) completed on August 19, 2024, revealed that in section C- Cognitive Patterns, the resident had been assessed to have a BIMS (Brief Interview for Mental Status, an assessment which measures short term memory and orientation to person, place, time, and situation) of 15, which indicated that the resident was fully cognitively intact.</p> <p>Review of Resident R97 MDS assessment, completed on August 12, 2024, revealed that in section C- Cognitive Patterns, the resident had been assessed to have a BIMS score of 15, which indicated that the resident was fully cognitively intact.</p> <p>Observation of the lunch meal was conducted on October 2, 2024, at 1:34 p.m., in the second floor dining room. Review of the menu for the day posted on the wall revealed that the main course for the meal was cheese ravioli, and sides included caesar salad. Residents R72 and R97 were noted to be seated at the same table.</p> <p>The meal ticket for Resident R97 was printed with the main course as spaghetti noodles; this was crossed out in pen, and cheese ravioli was written instead. His plate had cheese ravioli in a white sauce. His tray did not have a salad. At time of meal service, Resident R97 stated I keep telling them I don't want ravioli. Resident R97 then requested a hamburger as a substitute and was told the kitchen did not have any available. He then requested a peanut butter and jelly sandwich on whole wheat bread.</p> <p>At this time, Resident R72 also requested an alternate meal of a turkey and cheese sandwich, as he did not like the ravioli either. Observation of his tray revealed that his salad appeared limp and soggy. Resident R72 said of the salad it looks nasty.</p> <p>At 1:52 p.m., a dietary aide entered the dining room with three sandwiches, one ham and cheese, one turkey and cheese, and one tuna salad. Resident R97 was given the ham and cheese sandwich instead of the peanut butter and jelly he had requested. The resident accepted the sandwich, and stated, It's not what I asked for, but I guess I'll eat it if that's all they have.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The aide then looked at Resident R72's meal ticket, which stated that his dislikes included turkey and tuna. Resident R72 was told that due to the information on his ticket, he could not have either of the sandwiches, and then was offered a peanut butter and jelly sandwich. He then stated, I have no choice, so okay. The aide then said he would return to the kitchen to prepare a new sandwich.</p> <p>At 1:57 p.m. the dietary aide returned to the dining room and offered Resident R72 an egg salad sandwich, which the resident refused, stating he doesn't like egg salad.</p> <p>At 2:06 p.m. the dietary aide returned to the dining room and served Resident R72 a peanut butter and jelly sandwich which was served on a hamburger bun. The resident accepted the sandwich, but stated, I'm only eating it because I'm hungry and at this point it's better than nothing.</p> <p>An interview was conducted with Employees E4, the Food Services Manager and Employee E11, the registered dietitian, on October 3, 2024, at 10:14 a.m. Employee E4 stated that the sandwiches should have been prepared before the meal service, both for those who have them ordered, and for residents who might request them, and confirmed that the meal service provided to Residents R72 and R97 on October 2, 2024 was not appropriate. She also stated that the reason the salad had looked unappetizing was that kitchen staff had used too much dressing. Employee E4 also confirmed that the kitchen did have hamburgers available, as Resident R97 originally requested.</p> <p>Employee E11 confirmed that Resident R97 was served ravioli instead of the spaghetti despite documentation that the resident did not like ravioli. When asked if staff were aware of the resident's dislikes, Employee E11 stated that a dislike of ravioli was documented for the resident, but that kitchen staff were unable to access it while assembling lunch trays. She then stated that the spaghetti substitute was on the list of items for the kitchen staff to prepare on October 2, 2024 but that it had not been cooked. She stated that as the spaghetti was not available for lunch service, the staff made the choice to serve Resident R97 ravioli.</p> <p>Observation on October 1, 2024 at 12:30 p.m. revealed Resident R65 received barbecued pork, baked beans and creamed spinach. Observation of Resident R65 ' s meal ticket revealed Resident R65 ' s selection was ground Salisbury steak with brown gravy, parmesan noodles, creamed spinach, dinner roll with margarine and applesauce. Resident R65 did not receive a dinner roll, margarine and applesauce.</p> <p>Interview on October 1, 2024 at 12:40 p.m. with Food Service Director confirmed that Resident R65 did not receive her preferences that were listed on her mealticket.</p> <p>28 Pa. Code: 211.6(b)(d) Dietary services</p> <p>28 Pa. Code 211.29 (j) Resident rights.</p>		

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  10/03/2024
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>44882</p> <p>Based on observation, review of facility documents, and interview with staff and residents, it was determined that the facility did not ensure that meals and snacks were provided at appropriate times for two of two floors observed (First and Second floor).</p> <p>Findings include:</p> <p>Review of the list of facility mealtimes revealed that lunch in the Second floor dining room is scheduled to be served at 12:00 p.m. every day.</p> <p>Observations of the Second floor dining conducted on September 30, 2024, at 11:45 a.m. revealed that residents were seated in the dining room, some with clothing protectors already in place.</p> <p>Continued observation revealed that the cart containing the lunch trays was delivered at 1:29 p.m. Staff began to distribute the trays at that time. The final tray was delivered at 1:48 p.m.</p> <p>Observations of the Second floor dining room conducted on October 2, 2024, at 12:07 p.m. revealed that again residents were seated in the dining room, some with clothing protectors in place. The cart of lunch trays was delivered to the floor at 1:28 p.m., with the final tray served at 1:35 p.m. The final meal for residents who requested substitutions was delivered at 2:06 p.m.</p> <p>28 Pa. Code: 201.14(a) Responsibility of license</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46993</p> <p>Based on review of clinical record and interview with staff, it was determined facility did not ensure that medical records were complete and accurately documented in accordance with accepted professional standards of for two of 23 residents reviewed (Residents R6 and R58)</p> <p>Findings include:</p> <p>Review of clinical records for Resident R6 revealed that he was admitted to the facility on [DATE], and had diagnoses of acute osteomyelitis (bone infection) of the left ankle and foot, open wound of the left foot, and peripheral vascular disease (a condition in which blood vessels outside of the brain and heart narrow, spasm, or become blocked; this can lead to reduced blood flow and potential tissue damage).</p> <p>Continued review revealed a wound care consultation note written by Employee E12, Registered Nurse Practitioner and wound specialist, written on September 30, 2024. The note stated, the resident has a treatment change .reference the recommended orders for updated treatments . Recommend changing treatment to left heel to silver alginate.</p> <p>The note also stated Left heel pressure (wound) treatment recommendations: 1. Cleanse with Acetic Acid 1% (vinegar). 2. Apply silver alginate (an absorbent material which incorporates silver as an antimicrobial agent) to base of the wound. 3. Secure with ABD (abdominal pads; a soft, absorbent item used in wound care), rolled gauze. 4. change daily, and PRN (as needed).</p> <p>Review of the physician orders for Resident R6 revealed an order for Acetic acid solution .apply to left heel topically one time a day for wound care, dated September 30, 2024. As of October 3, 2024, no order was found for the silver alginate, or the rest of the treatment recommended.</p> <p>In an interview on October 3, 2024, at 12:01 p.m., with Employee E13, wound care RN, she confirmed that she had spoken to the resident's attending physician regarding the recommendations, and that they were approved. She stated, I have my cheat sheet [of wound care treatments], and I know he said to use the alginate, so I've been using it. I thought I put it in the order, but I guess I didn't. She confirmed that the order should have been placed at the time the physician approved it.</p> <p>Observations of Resident R58 on Wednesday, October 2, 2024, at 9:30 a.m., on Second floor unit, revealed a posting on resident's room wall, indicating Resident R58 speaks Cantonese.</p> <p>Interview with Licensed nurse, Employee E9, on October , 2024, at 9:35 a.m., confirmed Resident R58 is of Asian descent and speaks Cantonese.</p> <p>Review of resident R58's Minimum Data Set (resident assessment and care screening/MDS) on October 2, 2024, at 12:00 p.m. revealed Resident R58 to be black or African American.</p> <p>Further review of resident R58's clinical record revealed 'Notice of Medicare Non-Coverage,' form labeled under another resident's name, Resident R21.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Renaissance Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  4712 Chester Avenue Philadelphia, PA 19143	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of resident R58's clinical record revealed 'change in condition assessment,' completed on April 11, 2024, indicating altered mental status started on October 11, 2024.</p> <p>Further review of Resident R58's clinical record revealed a medical diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, (diagnosed in 2015) and unspecified psychosis not due to a substance or known physiological condition, (diagnosed in 2022).</p> <p>Review of progress notes completed by facility's Nurse Practitioner, Employee E10, dated October 28, 2022, at 6:41 p.m., states resident R58 psychiatry diagnosis: Dementia with psychosis</p> <p>28 Pa. Code 211.12(c) Nursing service</p> <p>28 Pa. Code 211.12(d)(1) Nursing service</p> <p>28 Pa. Code 211.12(d)(2) Nursing service</p> <p>28 Pa. Code 211.12 (d)(5) Nursing service</p>		