STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395628	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Healthcare & Rehabilitation Center	4712 Chester Avenue Philadelphia, PA 19143

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations of the meals and dietary services, reviews of the resident council and food committee meeting minutes, interviews with residents and staff and reviews of policies and procedures, it was determined that the facility failed to provide meals at regular time frames and in accordance with resident needs and preferences. (Residents R2, R28, R68, R97, R114 and R116). Findings include: A review of the facility's policy titled food and nutrition services dated October 2001 revealed that it was the responsibility of the facility to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs and preferences. The policy also said that meals would be provided within the scheduled mealtime frame and in accordance with the resident's medication requirements. The policy also said that meals were scheduled at regular times to assure that each resident receives at least three meals a day. Mealtimes were to be posted in the facility in common areas. Observations of the noon meal services for the residents living on the second-floor nursing unit on September 8, 2025, revealed that the meal delivery times that were established and posted throughout the facility were not being adhered to. The residents were observed sitting in the dining room or in their rooms at 11:30 a.m., waiting for their noon meal to arrive at 12:00 p.m., the food beverage delivery from the dietary services department was not complete until 1:30 p.m., one hour and a half beyond the established mealtime schedule. The residents were heard asking the staff where the foods and fluids were being kept, since they were hungry, after waiting for two hours for the final meal truck to be delivered to the second-floor nursing unit. A review of the facility's established mealtime scheduled for the second-floor nursing unit revealed that meals were supposed to arrive between 12:00 p.m. and 12:40 p.m. The first-floor nursing unit meal trays were listed and scheduled for arrival at 11:50 a.m.Interview with the director of dietary services, Employee E7, at the time of the above observation revealed that there were new staff members in the kitchen that were not familiar with their job responsibilities. The director of dietary services confirmed that the meals were not being delivered to the nursing units promptly and in accordance with the established mealtime scheduled that was posted on each nursing unit. Interview with licensed practical nurse, Employee E3, at 9:30 a.m., on September 9, 2025, confirmed that the nursing staff on second floor had been waiting at least an hour beyond the established mealtime schedule on a daily basis for several months. A review of the June 26, 2025, resident council and food committee meeting minutes revealed that the residents were concerned about the late delivery of meal trays to the nursing units. A review of the resident council and food committee meeting minutes for July 31, 2025, revealed that residents were not happy that food trucks and meals were arriving late to the nursing units. A review of the resident council and food committee meeting minutes for August 28, 2025, revealed that the residents were concerned about the food truck delivery and meal delivery to the nursing units reporting that the dietary services were not operating in a timely manner. A group meeting was held with alert and oriented residents on September 09, 2025, at 11:00 a.m. Present at the meeting were Resident's R2, R28, R68, R97, R114 and R116. When the group was asked if there had been a problem with meals being late, all residents agreed that the meals have (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been late, like yesterday. Resident R6 said that recently, in the past few weeks the meals have been late a lot and added that the food is not always warm when he gets it. Resident R4 added that her food is late and often cold too. During observations on first floor unit, dining room, on September 8, 2025, at 12:00 noon residents received beverages at 12:33 pm and were not served meals until 1:00 pm. 28 PA. Code 211.10(a)(b)(c)(d) Resident care policies28 PA. Code 201.14(a) Responsibility of licensee28 PA. Code 201.18c(b)(1)(3)(6) Management

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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. Based on review of clinical records, review of facility policy and interview with staff, it was determined facility did not ensure to develop and care plan related to a resident's diagnosis for one of six residents reviewed (Resident R133)Findings include: Review of facility policy ?Comprehensive Person- Centered Care Plans,' revised March 2022, indicated that the care plan reflects currently recognized standards of practice for problem areas and conditions.Review of Resident R133's clinical record revealed the diagnoses of osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down), osteoporosis (condition in which bones become weak and brittle), osteopenia (bone loss).Review of facility provided documentation revealed that on May 6, 2025, Resident R133 complained of pain to the right side, stating that maybe it occurred when Nurse aide, Employee E9, was repositioning her in bed. X-ray revealed a fracture to the 9th rib. Per hospital records resident is at high risk for fractures due to severe osteoporosis.Further review of facility provided investigation report, completed by the Director of Nursing on June 5, 2025, revealed that the medical director reviewed the resident's condition and noted that resident has had severe osteoporosis since 2016 with very high risk for fractures.Review of R133's care plan revealed no evidence of goals or interventions related to resident's high risk for fractures and medical diagnosis of osteoporosis.Interview conducted on September 11, 2025 at 11:00 am with the Director of Nursing confirmed that there was no care plan developed related to the resident's diagnosis of osteoporosis. 28 Pa Code 211.10(a) Resident care policies28 Pa. Code 211.12(d)(1) Nursing services

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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. Based upon review of clinical records, interview with staff and review of facility documentation, it was determined that the facility did not ensure a resident receive treatment and care in accordance with professional standards of practice, to a laceration identified after a fall incident for one resident of 24 resident records reviewed (Resident R17).Findings include:Review of Resident R17's clinical record revealed that the resident was admitted to the facility in March 2022 with the diagnosis of dementia. The resident was assessed to be at high risk for falls. Review of the information submitted on July 9, 2025, to the State Survey Agency revealed that on July 7, 2025, Resident R17 was lowered to the floor by a nurse aide when the resident was being toileted. The resident, who was soiled received a shower after the incident and it was then the staff noted that the resident was bleeding under her right axillary (armpit area).Review of Resident R17's clinical record revealed no evidence of a clinical assessment completed at the time that the nor monitoring by nursing when the wound was first discovered. A late entry note created on July 13, 2025, that detailed the resident had a fall on July 7, 2025, at 10:39 a.m. and noted that Skin issues had not been evaluatedFurther review of Resident R17's clinical record revealed the following morning on July 8, 2025, the wound was assessed by the wound specialist that described the wound as a large open area with muscle exposure with sanguineous (bright red in color) moderate discharge from the resident's right arm. After this assessment the resident was sent 911 to the hospital for further evaluation.Review of Resident R17's July 8, 2025, hospital records described the wound as a laceration, 7 x 5 cm, deep to muscle that required sutures.Interview with the Director of Nursing on September 11, 2025, at 2:00 p.m. was unable to show evidence of the nurse's initial assessment of the wound, treatments, physician orders, and/or ongoing monitoring once the wound was found, prior to Resident R17 transfer via 911 to the hospital.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based upon review of clinical records and interviews with resident and staff, it was determined the facility failed to ensure that a resident received services to maintain vision for one of 24 resident records reviewed (Resident R83). Findings include: Review of Resident R83's clinical record revealed that the resident was admitted to the facility in November 2021, with the diagnosed with diabetes. Interview with the resident on September 8, 2025, at 9:30 a.m. stated it had been a while since her last eye doctor's appointment and said, I think I'm due Review of Resident R83's clinical record revealed an ophthalmologist appointment dated March 6, 2024, for suspected glaucoma and cataracts instructed to monitor annually. Further review of the medical record revealed no further appointments had been made. This was confirmed with the Director of Nursing on September 10, 2025, at 11:30 am when the facility could not locate a follow-up appointment for Resident R83's yearly evaluation for ophthalmology. 28 Pa Code 211.12(d)(3) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on review of clinical records and facility documentation and interviews with staff, it was determined that the facility failed to maintain ongoing communication between the facility and a dialysis provider for two of three residents receiving dialysis reviewed (Residents R1, and R32).Findings include:Review of facility policy ?Care of Resident with End Stage Renal Disease,' revised September 2010, stated that staff caring for residents with ESRD (End Stage Renal Disease), including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents, including education and training of staff on the type of assessment data that is to be gathered about resident's condition on a daily or per shift basis.Further review of policy indicated that agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: how information will be exchanged between the facilities.Review of Resident R32's clinical record revealed the medical diagnoses of end stage renal disease, dependance on renal dialysis, type 2 diabetes mellitus (failure of the body to produce insulin).Further review of Resident R32's clinical record revealed a physician order for dialysis services on Mondays, Wednesdays and Fridays.Review of Resident R32's communication report on unknown date revealed the following information missing: vital signs, code status, changes in condition, and facility's nurse name/date.Review of Resident R32's dialysis communication report dated April 16, 2025, revealed missing pre-weight information and missing post weight/total fluid removed information.Review of Resident R32's dialysis communication report dated April 18, 2025, revealed missing pre-weight information as well as all missing resident information not completed by dialysis staff.Review of R32's dialysis communication report dated April 28, 2025, revealed missing pre-weight information.Review of R32's dialysis communication report dated May 14, 2025, revealed missing pre-weight informationReview of R32's dialysis communication report dated June 30,2025, revealed missing post - weight and total fluid volume removed information.Review of Resident R57's clinical record revealed a physician's order for hemodialysis every Tuesday, Thursday and Saturday with a 10:45 a.m. chair time at a local dialysis center. Further review of Resident R57's dialysis log record revealed that none of the four pages available to review from September 2025, were completed by the dialysis center or signed by the dialysis center nurse. Interview with the Unit Manager, Employee E3, on September 10, 2025, at 12:15 p.m. confirmed that the dialysis center had failed to complete the clinical documentation on all four of the pages in September for Resident R57. She stated that they often have to call the dialysis center for the pre and post weights. Interview with the Unit Clerk, Employee E6, on September 10, 2025, at 12:30 p.m. confirmed that the dialysis center had not completed the log pages for Resident R57 for September. She stated that it was not like the dialysis center not to complete this and that she would have to call them. An interview on September 10, 2025, at 2:15 p.m. with the Director of Nursing, acknowledging that the log sheets should be completed each time the resident goes to dialysis by both the facility nurse and the dialysis center staff. 28 Pa. Code: 211.10(c) Resident care policies 28 Pa Code 211.5(f)(ix) Clinical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Pharmacy Services Facility did not ensure to provide medications and/or biologicals, as ordered by the prescriber, to meet the needs of resident ([NAME]) Based on observations, review of resident's clinical record and interview with staff, it was determined that facility failed to ensure timely reordering and availability of mediations from pharmacy for one of four residents reviewed (Resident R24)Findings include:Review of facility policy ?Reordering, Changing, and Discontinuing Medication Orders.' Revised February 2023, indicated that refills can be requested via facilities EMAR system; this is the most preferred method. Facility may also request refills by placing the ?refill' strip portion of the medication label on the Refill Order Form and faxing it to the pharmacy.Review of facility's policy ?Administering Medications,' revised April 2019, indicated that if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall indicate on the MAR, and the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.Review of Resident R24's clinical record revealed the resident's diagnoses of paroxysmal atrial fibrillation (A-Fib, a type of heart rhythm disorder where the heart's upper chambers beat irregularly and rapidly for a short period of time), high blood pressure, hemiplegia/hemiparesis (paralysis to one side of the body) following cerebral infarction affecting right dominant side.Review of Resident R24's clinical record revealed a physician order for calcium + vitamin D3 oral tablet 600-5 mg-mcg supplement to be administered twice daily.Further review of Resident R24's clinical record revealed a physician order for Apixaban oral tablet 5 mg to be administered every 12 hours for A-FIB.During medication administration observation on September 10, 2025, at 10:40 am, Licensed nurse, Employee E8, did not administer supplement and Apixaban due to unavailability of medications; further indicating that Apixaban was untimely re-ordered on September 10, 2025.Review of Resident R24's nurses notes, dated September 10, 2025 at 10:03 am, revealed CRNP (Certified Registered Nurse Practitioner)/MD (physician) is aware of resident missed dose of Apixaban 5 mg, medication will be delivered from pharmacy.Review of Resident R24's medication administration record (e-MAR) revealed Employee E8 marked Apixaban 5 mg as given on September 10, 2025 at 10:56 am.Interview with facility's director of nursing on Thursday, September 11, 2025 at 1:30 pm, confirmed R24 missed dose of apixaban 5 mg on Wednesday, September 10, 2025, as well as inaccurate e-MAR documentation.28 Pa Code 201.18(b)(2) management28 Pa Code 211.9(a)(1)(k) pharmacy services28 Pa Code 211.12(d)(1)(3)(5) nursing services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations during medication administration, review of clinical records, facility policies and procedures, as well as interview with staff, it was determined that the facility did not ensure the medication error rate was less than five percent.Findings include: The facility's medication error rate was 8 percent based on observation of 25 medication opportunities with two medication errors observed.Review of facility policy ?Reordering, Changing, and Discontinuing Medication Orders,' revised February 2023, indicates that refills can be requested via facilities EMAR system; this is the most preferred method. Facility may also request refills by placing the ?refill' strip portion of the medication label on the Refill Order Form and faxing it to the pharmacy.Review of facility policy ?Administering Medications,' revised April 2019, indicates that medications are administered within one hour of their prescribed time, unless otherwise specified.Review of Resident R24's clinical record revealed the diagnoses of paroxysmal atrial fibrillation (A-Fib, a type of heart rhythm disorder where the heart's upper chambers beat irregularly and rapidly for a short period of time), high blood pressure, hemiplegia/hemiparesis following cerebral infarction affecting right dominant side.Further review of Resident R24's clinical record revealed a physician order for Apixaban oral tablet 5 mg to be administered every 12 hours for A-FIB, at 9 am and 9 pm.Review of Resident R24's clinical record revealed a physician order for calcium + vitamin D3 oral tablet 600-5 mg-mcg supplement to be administered twice daily.During medication administration observation on September 10, 2025, at 10:40 am, Licensed nurse, Employee E8, did not administer supplement and Apixaban due to unavailability of medications; further indicating that Apixaban was untimely re-ordered from pharmacy on September 10, 2025.Interview with facility's director of nursing on Thursday, September 11, 2025, at 1:30 pm, confirmed that Resident R24 did not receive Apixaban 5 mg and did not receive calcium + vitamin D3 oral tablet 600-5 mg-mcg supplement as prescribed.28 Pa Code 211.9(a)91) pharmacy services28 Pa Code 211.12(5) nursing services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations of care and services, interviews with residents and staff and reviews of policies and procedures, it was determined that for one of two residents reviewed for oral health services, the facility failed to provide prompt and routine dental care for each resident. (Resident R9) Findings include: A review of the facility's policy titled dental services dated December 2001, revealed that it was the responsibility of the facility to ensure that each resident had oral health examinations and assessments. The policy also said that it was the facility's responsibility to provide each resident with routine and emergency dental care. The policy indicated that the routine and emergency dental care would be provided by a contracted dental group. Observations of Resident R9 on September 8, 2025, revealed that this resident was in need of oral care. The need for dental cleaning of the resident's teeth was apparent upon speaking with the resident. An accumulation of food debris was observed between the teeth when resident was expressing a smile. Clinical record review revealed that Resident R9 had been evaluated by the dental hygienist on July 18, 2025. The hygienist assessment indicated that Resident R9 had moderate to severe calculus, moderate to severe plaque and moderate to severe gum bleeding. The hygienist indicated that Resident R9 was not tolerating the cleaning and needed to be examined by a dentist. The dental assessment dated [DATE], indicated that Resident R9 complained of teeth pain and asked to be examined by a dentist. Interview with the licensed practical nurse, Employee E3 at 9:30 a.m., on September 9, 2025, revealed that this nurse was familiar with the oral care needs of Resident R9. The licensed nurse, Employee E3, confirmed that there were no routine dental services scheduled to treat the oral needs (teeth pain, plaque, calculus and bleeding gums) of Resident R9. 28 PA. Code 211.10(a)(b)(c)(d) Resident care policies 28 PA. Code 211.12(d)(1)(3)(5) Nursing services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical records review and staff interview, it was determined that the facility failed to maintain accurate medication administration records for one of 23 residents reviewed. (Resident R24)Findings include:Review of Resident R24's clinical record revealed the resident's diagnoses of paroxysmal atrial fibrillation (A-Fib, a type of heart rhythm disorder where the heart's upper chambers beat irregularly and rapidly for a short period of time), high blood pressure, hemiplegia/hemiparesis (paralysis to one side of the body) following cerebral infarction affecting right dominant side.Review of Resident R24's clinical record revealed a physician order for calcium + vitamin D3 oral tablet 600-5 mg-mcg supplement to be administered twice daily.Further review of Resident R24's clinical record revealed a physician order for Apixaban oral tablet 5 mg to be administered every 12 hours for A-FIB.During medication administration observation on September 10, 2025, at 10:40 am, Licensed nurse, Employee E8, did not administer supplement and Apixaban due to unavailability of medications; further indicating that Apixaban was untimely re-ordered on September 10, 2025.Review of Resident R24's medication administration record (e-MAR) revealed Employee E8 marked Apixaban 5 mg as given on September 10, 2025 at 10:56 am.Interview with facility's director of nursing on Thursday, September 11, 2025 at 1:30 pm, confirmed R24 missed dose of apixaban 5 mg on Wednesday, September 10, 2025, as well as inaccurate e-MAR documentation.28 Pa. Code 201.18(b)(2) Management28 Pa. Code 211.12(d)(1) Nursing services