STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395749	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rittenhouse Post Acute	Penn Med Rittenhouse Campus 1800 Lombard St 5th FL Philadelphia, PA 19104

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 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 clinical record review and staff interview, it was determined that the facility failed to ensure that a plan of care was related to the diagnosis of seizure for one of two residents reviewed. (Resident R1)Findings include:Review of Resident R1's August 2025 physician orders included the diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest); back pain; convulsions (rapid, involuntary muscle contractions that cause uncontrollable shaking and limb movement that can happen during of without seizures) and cerebral infarction (a stroke). Continued review of the resident's physician's orders indicated that the resident also was being prescribed medication for the treatment of seizures (a sudden burst of electrical activity in the brain. It can cause changes in behavior, movements, feelings and levels of conscious).Review of the resident's person-centered plan of care did not include a plan of care for the resident's seizure diagnosis to ensure that appropriate goals and interventions are included and in place for this care area.During an interview with the Director of Nursing (DON) on August 19, 2025, at 1:46 p.m. the DON confirmed during the interview that the resident did not have a car plan in place for seizures.28 Pa Code 211.11(d) Resident care plan 28 Pa. Code 211.12(c(1))Nursing services 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on review of clinical records, review of facility policy and staff interview, it was determined that the facility failed to ensure that medication was deliver timely from the pharmacy to be administer to the resident as ordered by the physician for 1 out of 2 residents reviewed (Resident R1). Findings include: Review of the facility policy, Policy Services Overview, with a revision date of April 2019 indicated that the facility shall contract with a licensed consultant pharmacist to help it obtain and maintain timely and appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet state and federal requirements. The policy also indicated that pharmacy services are available to residents 24 hours a day, seven days a week and indicated that residents will have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner.Review of the Resident R1's August 2025 physician orders included a physician's order with a start date of August 10, 2025. at 9:00 a.m., for the resident to be administered 1-100 milligram tablet of the medication, Lamotrigine, once a day (9:00 a.m.) by mouth. The physician orders indicated that the medication was being prescribed for the treatment of the resident's seizure diagnosis. Review of Resident R1's August 2025 physician orders included an order with a start date of August 9, 2025, at 9:00 p.m. for the resident to administer 1-125 milligram tablet of the medication, Lamotrigine, by mouth at bedtime (9:00 p.m.). The physician orders indicated that medication was being prescribed for the treatment of the resident's seizure diagnosis. Lamotrigine Oral Tablet (Lamotrigine)Give 125 mg by mouth at bedtime for seizures.Continued review of the August 2025 physician orders included a physician's order, with a start date of August 9, 2025, at 9:00 p.m. for the resident to be administered 1-50 milligram tablet of the medication, Lacosamide, by mouth every morning (9:00 a.m.) and at bedtime (9:00 p.m.) for seizure disorder: Vimpat Oral Tablet 50 MG (Lacosamide) Give 1 tablet by mouth every morning and at bedtime for Seizure Disorder.Review of the Medication Administration Record (MAR) indicated that on August 9, 2025, the resident was not administered her 9:00 p. m. dose of the medication, Lacosamide. Continued review of the MAR indicated that the resident was also not administered her 9:00 p.m. dose of the medication, Lamotrigine on August 9, 2025. Review of a nursing note dated August 10, 2025 at 6:03 a.m. by nursing staff documented that the resident did not receive her seizure 9:00 p.m. seizure medications during the 7:00 p.m. through the 7:00 a.m. nursing shift. Patient did not receive Seizure medications this shift. Doctor . made aware.During an interview with the Director of Nursing (DON) on August 19, 2025, at 11:45 a.m. the DON confirmed that the resident was not administered the above referenced seizure medications, as ordered by the physician, because they were not delivered by the facility's pharmacy. 28 Pa Code 211.9 (d) Pharmacy services28 Pa Code 211.9 (l)(1) Pharmacy services28 Pa Code 211.9 (l)(2) Pharmacy services