

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395749	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2025
NAME OF PROVIDER OR SUPPLIER Rittenhouse Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>46508</p> <p>Based on review of documentation and staff interview, it was determined the facility failed to ensure residents were provided a Notification of Medicare Non-Coverage (NOMNC) for one of three residents reviewed (Resident R66).</p> <p>Findings include:</p> <p>Review of facility documentation revealed no evidence that the Notification of Medicare Non-coverage was provided to Resident R66.</p> <p>Interview with Director of Social Services, Employee E3 conducted on May 14, 2025, at 11:05 a.m. confirmed that she was responsible for sending the Notice of Medicare Non-Coverage to residents who were discharged from Medication Part A with remaining Medicare days.</p> <p>Continued interview with Social Services, Employee E3 revealed that Resident R66 was scheduled to leave at a planned date of September 27, 2024, but requested to leave on September 25, 2025. Further, Employee E3 also revealed that Resident R66 informed Employee E3 of his wishes to go home earlier a few days before September 25, 2025. Further, Employee E3 also revealed that she informed Rehab about Resident R66 wishing to leave earlier, and that rehab cleared the resident to go home. Employee E3 confirmed that she did not provide Resident R66 with a Notification of Medicare Non-coverage. Further Employee E3 also confirmed that should have been provided to Resident R66 with a Notification of Medicare Non-coverage.</p> <p>28 Pa. Code 201.18(b)(1) Management</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>48347</p> <p>Based on observations, review of facility policy, review of clinical records, and staff in our view, it was determined that the facility failed to develop and implement a person center and comprehensive care plan related to resident's nutritional needs and weight loss for one resident. (Resident R1)</p> <p>Findings include:</p> <p>Review of facility policy titled Care Plans, Comprehensive Person Centered dated March 2022, revealed that a comprehensive person center care plan includes measurable objectives and timetables to meet all resident's physical, psychosocial and functional needs. The care plan includes the resident's goals upon admission, reflects currently recognized standards of practice for problem areas and conditions. When possible, the care plan interventions address the underlying source of the problem areas. Assessments of the residents are ongoing, and care plans are reassessed as information about the resident and the residents' conditions change. The interdisciplinary team reviews and updates the care plan when there has been a significant change in the residents' condition.</p> <p>Review of policy titled Weight Assessment and Intervention dated March 2022, revealed that resident weights are monitored for undesirable or unintended weight loss or gains. Undesirable weight change is evaluated, this evaluation includes recent target weight range, resident's calorie protein and other nutrient needs compared to the resident's current intake, the relationship between current medical condition or clinical situation and recent fluctuations in weight and whether and to what extent weight stabilizing or improvement can be anticipated. Care planning for weight loss or impaired nutrition is a multi-disciplinary effort and includes the physician nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate. Individualized care plan shall address, to extent possible the identified cause of weight loss, goals and benchmarks for improvement, and time frames and perimeters for monitoring and reassessment. Interventions for undesirable weight loss are based on careful consideration of the following; resident choice preferences, common nutrition, functional factors that may inhibit independent eating, environmental factors that may inhibit appetite, chewing and swallowing abnormalities, medications that may interfere with appetite, the use of supplementation or feeding tubes and end of life directives.</p> <p>Review of Review of resident R 1's admission minimum data set (MDS- a federal mandated assessment tool for all residents) dated December April 23, 2025, revealed that resident R1 was admitted into the facility April 16, 2025, 2024 with diagnosis' including Coronary artery disease(a heart disease that happens when coronary arteries cannot supply the heart with enough blood, oxygen and nutrients), hypertension(high blood pressure-a condition where the force of blood in the heart is consistently too high), diabetes(the body does not produce enough insulin or cannot properly use insulin, leading to high blood sugar levels), aphasia(inability to swallow), malnutrition(Lack of proper nutrition), and depression(persistent feeling of sadness and changes of how you think, sleep, eat , and act). Resident assessment with a cognitive BIMS (brief interview for mental status) score of 11, indicating the resident is moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident's weight summary dated April 16th, 2025, resident was recorded as being 118.0 pounds admission, April 23rd, 2025, resident reported being 107.6, indicating a 10.4-pound weight loss. After two weeks the resident was weighted again and was documented as 102.8 pounds, indicating a 4.8-pound weight loss.</p> <p>Review of resident R1's care plan revealed that Resident is at risk for malnutrition related to muscle fat wasting on NFPE (nutrition focused physical exam), need for modified food texture food, need for an ONS (oral nutrition supplements), altered nutrition related labs, increased metabolic needs and chronic medical diagnosis which was initiated April 22, 2025. The intervention for this focus was to provide a regular, thin liquid diet that noted I prefer the following foods: pescatarian diet A diet that is free of meat and chicken, primarily a plant-based diet with fish consumption.</p> <p>Further review of resident R1's care plan revealed no focus or intervention and goals of resident 's documented weight loss.</p> <p>Continued review of resident R1's care plan revealed there was no interventions of resident's preference of pescatarian diet and supplemental needs that accompany this diet.</p> <p>Interview with dietitian, employee E5, conducted on May 14, 2025, at 10:53 AM confirmed that the resident has documented weight loss which has not been included in the resident care plan. Employee E5 stated that she has worked with the kitchen staff to develop a pescatarian diet for resident R1. There is no indication that the facility has any documented menu choices for pescatarian residents' preferences.</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12(d)(5) Nursing service</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on review of facility policies and documentation, clinical records, and interviews with staff, it was determined the facility failed to ensure Resident R65 who required supervision/assistance with ambulation was accompanied by an escort during a medical appointment outside of the facility. This failure resulted in actual harm to Resident R65 who sustained a fall and fracture of nasal bone for one of four residents reviewed. (Resident R65)</p> <p>Findings include:</p> <p>Review of facility policy titled Transportation, Diagnostic Services dated December 2008, revealed under section Policy Statement indicated, Our facility will assist residents in arranging transportation to/from diagnostic appointments when necessary. Additional review of facility policy revealed under section Policy Interpretation and Implementation revealed the following: #1. Should it become necessary to transport a resident to a diagnostic service outside the facility, the social service designee or charge nurse shall notify the resident's representative (sponsor) and inform them of the appointment. #2. The resident's representative (sponsor) will be responsible for transporting the resident to his or her lab appointment. # 4. A member of the nursing staff, or social services, will accompany the resident to the diagnostic center when the resident's family is not available.</p> <p>Review of facility policy titled Safety and Supervision of Residents dated December July 2017, under section titled, Policy Statement revealed Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Additional review of facility policy indicated under section Policy Interpretation and Implementation, subsection Facility-Oriented Approach to Safety revealed the following, #1. Our facility-oriented approach to safety addresses risks for groups of residents. #2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI (Quality Assessment Improvement Program) reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. # 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents.</p> <p>Further review of same facility policy, under subsection titled, Individualized, Resident-Centered Approach to Safety revealed the following: #1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. #2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. #3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training, as necessary d. Ensuring that interventions are implemented.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled Falls - Clinical Protocol dated September 2012, under section titled Assessment and Recognition revealed the following: #1. As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling. #c. While many falls are isolated individual incidents, a significant proportion occur among a few residents/patients. Those individuals may have a treatable medical disorder or functional disturbance as the underlying cause. #2. In addition, the nurse shall assess and document/report the following: c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc. #3. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. #a. Risk factors for subsequent falling include lightheadedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion, visual impairment, and illnesses affecting the central nervous system and blood pressure.</p> <p>Review of Resident R65's clinical record revealed, Resident R65 was admitted to the facility on [DATE], with diagnoses including Obstructive Pulmonary Disease (lung and airway disease that restricts breathing), Muscle Weakness, Unspecified Abnormalities of Gait and Mobility.</p> <p>Review of Resident R65's admission MDS (Minimum Data Set- federally required resident assessment completed at specific intervals) dated December 19, 2024, subsection GG0115 revealed Functional Limitation in Range of Motion (Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days), A. Upper extremity (shoulder, elbow, wrist, hand) was coded 1- (Impairment on one side), section GG - Functional Abilities, D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed was coded 04(Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.), E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) was coded 04, I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space, J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns and K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space were all coded 04. Further section L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel. And M. 1 step (curb): The ability to go up and down a curb and/or up and down one step, were coded 88 (Not attempted due to medical condition or safety concerns).</p> <p>Review of Resident R65's care plan initiated December 13, 2024 revealed I have an ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Muscle wasting, Atrophy. Care plan interventions/tasks include the following: ambulation: I require supervision with ambulation. Transfers: I require supervision/setup with transfers.</p> <p>Review of the Resident R65's Physical Therapy Evaluation and Treatment Plan, under section Functional Mobility assessment dated [DATE], revealed the following: Transfers, Resident R65 requires SBA (standby assist- someone must be always be standing behind the resident to provide physical assistance in case resident loses balance or to provide physical support as needed), Gait on level surfaces, Resident R65 requires SBA, Distance on Level Surfaces, can walk up to a distance of 150 feet, Assistive Device: 2 wheeled walker.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident R65's Physical Therapy Evaluation and Treatment Plan, revealed for uneven surfaces indicated DNT (did not test- resident has not been evaluated on his ability to ambulate safely on uneven surfaces), Stairs was indicated DNT, number of stairs- 0 steps, Negotiated stairs-DNT ([Resident R65] has not been evaluated on his/her ability to safely go up and down stairs and to navigate stairs, Community Ambulation (ambulating outside of the facility) = SBA Further, under section Sensation/Sensory =IMPAIRED (impaired-not functioning normally), Touch Pressure=IMPAIRED (history of mild neuropathy bilateral feet).</p> <p>Review of Resident R65's Physical Therapy Assessment Summary dated December 13, 2024, revealed Resident R65 presented with deficits in cardiovascular endurance, dynamic balance (ability to maintain control of one's center of mass while the body is in motion or experiencing external forces. It involves adjusting and controlling the body's position in space while moving, walking, and other activities that require balance), functional strength, and activity tolerance limiting participation in functional mobility. Further, Resident R65 was below baseline levels. Resident R65 required SBA (standby assist) for functional transfers, with picking up object from ground and to ambulate 150 feet with rolling walker. Further additional functional mobility was not assessed due to increased fatigue.</p> <p>Review of Resident R65's physical therapy treatment encounter dated December 17, 2024 revealed skilled intervention focused on outdoor mobility training, and ambulation over uneven surfaces: 1. Gait training over uneven surfaces, carpets, change in surfaces, navigating through elevators, 500 feet with rolling walker and supervision for balance and rolling walker management with one episode of minimal assist for mild LOB (loss of balance) when navigating over carpet stuck on rolling walker, 3. Outdoor gait training over inclined and declined surfaces and uneven sidewalks 500 feet without assistive device and Sup (supervision) (close supervision -resident within arm's length for safety in case resident loses balance) for balance due to mild increased sway, seated rest breaks required between trials to manage increased fatigue.</p> <p>Review of Resident R65's physician's order with start date of December 19, 2024 revealed an order for: Follow up with plastic surgery and reconstructive surgery on December 19, 2024 at 2:00 pm.</p> <p>Further review of Resident R65's clinical record failed to reveal physician order for LOAs (leave of absences) to go to medical appointment or instructions during LOA.</p> <p>Review of Resident R65's nursing notes dated December 13, 2024, December 15, 2024, December 18, 2024, and December 19, 2024 (time stamped 4:02AM), revealed ADLs/Functional Status: Exhibits Unsteady gait weakness.</p> <p>Review of Resident R65's nursing notes dated December 19, 2024 (1:16 p.m.), revealed Resident R65 left facility to attend a doctor's appointment using a rolling walker. Resident R65 was picked up by an ambulance transportation.</p> <p>Review of Resident R65's progress notes dated December 19, 2024, at 8:50 p.m., revealed Resident R65 returned to the facility from local hospital with a fractured nose.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of Resident R65's nursing note dated December 20, 2024, revealed the following: Resident R65 was alert and oriented x 4 (oriented to people, places, and time) with a BIMS (Brief Interview of Mental Status) of 15 (indicating full cognitive functioning), went LOA to an appointment via ambulance transport around 1 p.m. on December 19, 2024 at 4:30 p.m. Charge nurse called to check in on patient status and nurse was informed that patient was at a local hospital following a fall that occurred while out on appointment. Hospital's nurse informed Charge Nurse that Resident R65 will be transported back to the facility with paperwork. When asked [he/she] tripped while ambulating in the lobby of appointment building. Patient returned to facility with a Dx (diagnosis) of nasal fracture and sinus precautions.</p> <p>Review of facility document titled, Full QA (Quality Assurance) report signed by Director of Nursing, Employee E2 on December 20, 2024, revealed a statement from Resident R65 indicating; When I was walking past the lobby, there were a thick mats where my walker got caught up which made me trip and fall forward.</p> <p>Interview with Rehabilitation Department staff, Employee E8 conducted on May 15, 2025, at 12:05 p.m. confirmed that before Resident R65 fall incident on December 19, 2024, Resident R65 was still unsteady and required standby assist for ambulation (walking). Further interview with Employee E8 revealed that standby assist during ambulation means that someone must be always standing behind Resident R65 while the resident is ambulating, to provide resident with verbal cueing and or physical help or physical support if needed in order to prevent falling in case of a loss of balance.</p> <p>Interview with Director of Nursing (DON), Employee E2 conducted on May 15, 2025, at 12:30 p.m. confirmed the facility allowed Resident R65 to go out to a doctor's appointment without an escort. Further, Employee E2 revealed that the plan was for Resident R65's family to meet Resident R65 inside the doctor's office.</p> <p>Continued interview on May 15, 2025 with Director of Nursing, Employee E2, revealed Resident R65 was transported via ambulance from the facility to the building where the doctor's office was located. Resident R65 was dropped off by the ambulance in front of the building and Resident R65 proceeded to walk with a rolling walker into the building unassisted and without supervision, where the resident subsequently fell in the lobby resulting in a fracture of the nasal bone.</p> <p>The facility failed to ensure Resident R65, who required supervision/assistance with ambulation was provided with an escort to supervise the resident during a medical appointment which resulted in actual harm to Resident R65 after sustaining a fall and fracture to the nasal bone.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on review of facility policy, clinical record reviews and staff interviews, it was determined that the facility failed to monitor, implement and modify interventions consistent with the resident's assessed needs to maintain acceptable parameters of nutrition for two of sixteen resident records reviewed. (Residents R61 and Resident R1)</p> <p>Findings include:</p> <p>Review of facility policy on Weight Assessment and Intervention dated March 2022, section Policy Statement Resident weights are monitored for undesirable or unintended weight loss or gain. Section Policy Interpretation and Implementation Weight Assessment #1. Residents are weighed upon admission and at intervals established by the interdisciplinary team. #2. Weights are recorded in each unit's weight record chart and in the individual's medical record. #3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. a. If the weight is verified, nursing will immediately notify the dietitian in writing. #4. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. #5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight)/(usual weight) x 100]: a. 1 month - 5% weight loss is significant; greater than 5% is severe. Section Evaluation #1. Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. The evaluation includes a. the resident's target weight range (including rationale if different from ideal body weight); b. the resident's calorie, protein, and other nutrient needs compared with the resident's current intake; c. the relationship between current medical condition or clinical situation and recent fluctuations in weight; and d. whether and to what extent weight stabilization or improvement can be anticipated.</p> <p>Review of Resident R61's clinical record revealed that Resident R61 was admitted to the facility on [DATE], with diagnoses of Fracture of Lumbosacral spine ad pelvis.</p> <p>Review of resident R61's weight record revealed the following: On May 3, 2025, Resident R61's weight was 179.0 lbs. (pounds), On May 6, 2025, Resident R61's weight was 171.8 lbs., On May 13, 2025, Resident R61's weight was 169.8 lbs.</p> <p>Further review of Resident R61's clinical record revealed that there were no dietary notes until May 14, 2025. Review of Dietary note dated May 14, 2025, revealed a Weight Change Note as follow: WEIGHT CHANGE: Value: 169.8 -5.0% change [5.1%, 9.2] reweigh pending.</p> <p>Further review of Resident R61's weight record revealed that no reweigh was done. Last recorded weight was on May 13, 2025, at 169.8 lbs.</p> <p>Further, review of Resident R61's clinical record revealed that there was no documented evidence that the weight loss was addressed by the dietician Employee E5 or by staff at the facility.</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>Review of the nutrition care plan revealed that Resident R61 was at risk for malnutrition related to muscle/fat wasting, need for therapeutic diet, altered nutrition-related labs, increased metabolic needs, and chronic medical Dx. Date Initiated: 05/05/2025</p> <p>Further review of Resident R61's care plan revealed that the care plan was not updated to address the significant weight loss observed on May 3, 2025, May 6, 2025, and May 13, 2025.</p> <p>Interview with Dietician Employee E5 conducted on May 14, 2025, at 10:53 AM confirmed that Resident R61 had a 9.2 lbs. weight loss or 5.14% weight loss from May 3, 2025, to May 13, 2025, a 5.14% weight loss in 10 days. Further Employee E5 confirmed that she has not seen Resident R61 until May 14, 2025.</p> <p>Review of Review of resident R 1's admission minimum data set (MDS- a federal mandated assessment tool for all residents) dated December April 23, 2025, revealed that resident R1 was admitted into the facility April 16, 2025, 2024 with diagnosis' including Coronary artery disease(a heart disease that happens when coronary arteries cannot supply the heart with enough blood, oxygen and nutrients), hypertension(high blood pressure-a condition where the force of blood in the heart is consistently too high), diabetes(the body does not produce enough insulin or cannot properly use insulin, leading to high blood sugar levels), aphagia(inability to swallow), malnutrition(Lack of proper nutrition), and depression(persistent feeling of sadness and changes of how you think, sleep, eat , and act). Resident assessment with a cognitive BIMS (brief interview for mental status) score of 11, indicating the resident is moderate cognitive impairment.</p> <p>Review of resident R1's hospital record prior to entering the facility, dated April 15, 2025, revealed resident presented to the emergency rodiagnom on [DATE], following a fall with progressively worsening lower back pain., she was treated conservatively with pain control and early mobilization and was discharged on [DATE]th to a skilled nursing facility. This document included resident's current weight as 53.5 kilograms, 118 pounds dated April 15, 2025.</p> <p>Review of resident nutritional risk assessment dated [DATE]st, 2025, revealed resident is at risk for malnutrition with a score of 11.0. The resident's BMI (body mass index-measure of body fat based on height and weight) was 23.8(indicating resident is within normal body weight). Resident's most recent weight documented as 118 pounds on the admission April 16th, 2025. The resident estimated calories are 1501 to 1770. Resident R1's documented food intake revealed that intake meals 51 to 75% of estimated needs. The resident report she is pescatarian RD (registered dietician) will update diet preferences via food service director.</p> <p>Continue review of this assessment document revealed that this resident is at risk for malnutrition she presents a need for modified food texture, need for ONS(oral nutritional supplement), altered nutrition related to labs, increased metabolic needs, and chronic medical diagnosis with a plan to offer ensure plus 8 ounce via PO twice a day for low protein and albumin provides 350K Cal and 20 grams of protein.</p> <p>Review of resident recorded weights revealed on April 16, 2025(admission resident weight recorded as 118.0, April 23, 2025, resident's weight recorded as 107.6 pounds, May 7, 2025, resident's weight recorded as 102.8 pounds.</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>Review of resident clinical record dietary notes revealed that on April 30, 2025, resident R1 triggered for weight warning indication that resident R 1 has sustained a weight loss of 10.4 pounds 8.8% change. REWEIGHT PENDING. There was no indication that resident R1 was reweighed.</p> <p>Further review of resident R 1 clinical record dietary notes dated May 7, 2025, revealed that resident R 1 triggered weight warning indicating resident now recorded weight of 102.8, 12.7 % one-month weight loss. The RD met with resident to address recent significant weight change. Residents reported that occasionally her family provides her own food. RD offered Ensure clear once a day. Full comprehensive assessment to follow.</p> <p>Further review of resident R 1 clinical record dietary notes dated May 14, 2025, revealed</p> <p>Note Text: WEIGHT CHANGE: Value: 102.9Vital Date: 2025-05-13 14:13:00.0MDS: -5.0% change over 30 day(s) [12.7% , 15.0]-5.0% change [12.8% , 15.1]-7.5% change [12.8% , 15.1]-10.0% change [12.8% , 15.1]reweight pending. No indication that resident R 1 was reweighed.</p> <p>Interview with resident R 1 on May 13, 2025, at 10:48 a.m. revealed that this resident has concerns of diet and weight loss. Resident R1 stated that she has not been provided her dietary preference of a pescatarian diet.</p> <p>Interview with Resident R 1 on May 15, 2025, revealed that this resident was served a plate of French fries the previous evening for dinner.</p> <p>Interview with dietitian employee E5 conducted on May 14, 2025, at 10:53 AM revealed that she is aware of resident R1's recent weight loss, she believed the weight loss has been attributed to healing process, and the initial weight recorded may have been inaccurate. This employee was unable to provide any meal tracking or nutritional requirements for this resident. Employee E5 and has confirmed that a full comprehensive assessment addressing the residents weight loss, or any documented interdisciplinary team notification has not been completed.</p> <p>28 Pa. Code 211.12(c) Resident care policies</p> <p>28 Pa. Code: 211.12(c)(d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on review of clinical records, staff and resident interviews, it was determined that the facility failed to provide culturally competent, trauma informed care in accordance with professional standards of practice, accounting for the resident's past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of residents for two of two residents with diagnosis of PTSD (post-traumatic stress disorder). (Resident R60 and Resident R63)</p> <p>Findings include:</p> <p>Review of facility policy on Trauma Informed Care and Culturally Competent Care dated August 2022 revealed that under section Purpose To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Under section General Guidelines 1. Traumatic events which may affect residents during their lifetime include: a. physical, sexual and emotional abuse; b. neglect; c. interpersonal or community violence; d. serious injury or illness; e. bullying; f. forced displacement; g. racism; h. war; and i. generational or historical trauma. # 2. Trauma-informed care is based on Trauma-Informed and Resilience Oriented ([NAME]), evidence-based and emerging best practices. 3. For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. 4. Triggers are highly individualized. Under section Organizational Strategies #1. Evaluate the need for trauma-informed practices as part of the facility assessment. #2. Utilize the facility assessment to identify the cultural characteristics of the resident population, including language, religious or cultural practices, values and preferences. #3. Develop an organizational culture that supports all Trauma-Informed and Resilience Oriented ([NAME]) domains. These include: a. universal and early screening and assessment; b. resident-centered care and services; e. safe and secure environments; g. ongoing performance improvement and evaluation. #7. Establish an environment of physical and emotional safety for residents and staff. Under section Resident Screening #1. Perform universal screening of residents, which includes a brief, non-specialized identification of possible exposure to traumatic events. #2. Utilize screening tools and methods that are facility-approved, competently delivered, culturally relevant and sensitive. #3. Screening may include information such as: a. trauma history, including type, severity and duration; b. depression, trauma-related or dissociative symptoms; c. risk for safety (self or others); d. concerns with sleep or intrusive experiences; e. behavioral, interpersonal or developmental concerns; f. historical mental health diagnosis; g. substance use; h. protective factors and resources available; and i. physical health concerns. 4. Utilize initial screening to identify the need for further assessment and care. [NAME] section Resident Assessment #1. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. #2. Utilize licensed and trained clinicians who have been designated by the facility to conduct trauma assessments. #3. Use assessment tools that are facility-approved and specific to the resident population.</p> <p>Review of Resident R60's clinical record revealed that Resident R60 was admitted to the facility on [DATE], with diagnoses of but not limited to PTSD (Post Traumatic Stress Disorder).</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R60's admission MDS (Minimum Data Set-a federally required resident assessment completed at a specific interval) dated May 7, 2025, Section I - Active Diagnoses, I6100. Post Traumatic Stress Disorder (PTSD) was marked X indicating that resident had a diagnosis of PTSD.</p> <p>Further review of Resident R60's clinical record revealed no documented evidence that an assessment related to PTSD was conducted on Resident R60, Furtherer, there was no documented evidence that Resident R60 received services to address Resident R60's diagnoses of PTSD.</p> <p>Further review of Resident R60's clinical record revealed a psych note dated May 5, 2025. Review of the psych note dated May 5, 2025, revealed that Resident R60 was seen due to psychotropic use while in a rehabilitation setting. Further, there was no mention of Resident R60's diagnoses of PTSD in the psych evaluation.</p> <p>Review of Resident R60's care plans revealed no care plan addressing Resident R60's PTSD diagnoses.</p> <p>Review of Resident R63's clinical record revealed that Resident R63 was admitted to the facility on [DATE], with diagnoses of but not limited to PTSD (Post Traumatic Stress Disorder).</p> <p>Further review of Resident R63's clinical record revealed no documented evidence that an assessment related to PTSD was conducted on Resident R63. Furtherer, there was no documented evidence that Resident R63 received services to address Resident R63's diagnoses of PTSD.</p> <p>Review of resident R63's care plans revealed no care plan addressing Resident R63's PTSD diagnoses.</p> <p>28 Pa. Code 211.12(c)(d)(3)(5) Nursing services</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on review of facility policy, review of clinical records, and staff and resident interviews, it was determined that the facility failed to ensure one resident was free from significant medication error for 1 of 3 resident reviewed. (Resident R1)</p> <p>Findings include:</p> <p>Review a facility policy titled Administering Medications dated April 2019, revealed that all medications are administered in accordance with prescriber orders and residents may self-administer their medication only if the attending physician comment in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.</p> <p>Review of the National Institute of Health article titled Magnesium Fact Sheet for health professionals dated June 2, 2022, revealed magnesium is a nutrient that the body needs to stay healthy magnesium is an important for many processes in the body including regulating muscle and nerve function, blood sugar levels, and blood pressure and making protein, bone and DNA. Recommended intakes for magnesium and other nutrients are provided in a dietary reference intakes developed by the Food and Nutrition Board at the Institute of Medicine and the National Academies. Health risks from excessive magnesium too much magnesium from foods does not pose a health risk in healthy individuals because the kidneys eliminate excess amounts in urine however high doses of magnesium from dietary supplements or medications often result in diarrhea and can be accompanied by nausea and abdominal cramping. Very large doses of magnesium containing lads live in and acids providing more than 5000 milligrams a day have been associated with magnesium toxicity including fatal hyper magnesium [NAME]. The risk of magnesium toxicity increases with impaired renal function or kidney failure. Several types of medication that has potential to interact with magnesium supplements or affect the magnesium status.</p> <p>Review of Resident R1's clinical record physician's orders revealed no order for the supplement Magnesium.</p> <p>Observation of licensed nurse employee E6 on May 14, 2025 at 10:05 a.m. revealed licensed nurse employee E 6 administering morning medication to resident R1. During this observation a bottle of magnesium gummy vitamins 84 mg were viewed on the resident's table.</p> <p>Interview with Resident R1 at time of the above observation revealed that they are her vitamins and she takes them twice daily. Interview with licensed nurse employee E6 at time of the above observation confirmed that there was no order for this supplement and this nurse was unaware that resident R1 was consuming this supplement.</p> <p>28 Pa.Code 211.10(c) Resident Care Policies</p> <p>28 Pa. Code 211.12(c) Nursing Services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on review of facility policy, observation, and staff interview, it was determined that the facility failed to ensure that drugs ad biologicals are stored in a safe/secure environment in accordance with professional standards for one of one medication room and for one of sixteen residents observed. (Resident R60)</p> <p>Findings include:</p> <p>Review of facility policy on Medication Labeling and Storage dated February 2023, under section Policy Statement, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Under section Policy Interpretation and Implementation, subsection Medication Storage 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. 5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. 6. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly. Subsection Medication Labeling #1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. # 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.</p> <p>Review of Resident R60's clinical record revealed that Resident R60 was admitted to the facility on [DATE], with diagnoses of but not limited to Chronic Obstructive Pulmonary Disease (COPD-lung an dairway disease that restrict breathing).</p> <p>Review of Resident R60's physician's orders revealed an order for Fluticasone-Salmeterol 500-50 MCG/ACT Aerosol Powder, breath activated 1 puff inhale orally every 12 hours for COPD Instruct patient to rinse mouth to prevent thrush. -start date-05/01/2025</p> <p>Observation of Resident R60's environment conducted on May 13, 2025, at 9:26 a.m. during the initial tour of the facility revealed the inhaler Fluticasone with Resident R60's name on it on top of the overbed table.</p> <p>Interview with Resident R60 conducted at the time of the observation revealed that the nurses gave her the Fluticasone. Further interview revealed that Resident R60 did not remember the name of the nurse who gave her the Fluticasone Inhaler.</p> <p>Follow-up observation conducted with Director of Nursing Employee E2 on May 13, 2025, at 10:04 am revealed that the Fluticasone inhaler was still on top of Resident R60's overbed table.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with DON (Director of Nnursing) Employee E2 conducted at the time of the observation confirmed that Fluticasone inhaler labelled with Resident R60'd name was on top of Resident R60's overbed table.</p> <p>Observation of the medication refrigerator located in the medication room conducted on May 14, 2025, at 9:57 a.m. with DON, Employee E2 revealed an open vial of tuberculin purified protein derivative.</p> <p>Further observation revealed that the open vial of tuberculin purified protein derivative was not dated.</p> <p>Interview with Employee E2 conducted at the time of the observation confirmed that the vial of tuberculin purified protein derivative was not dated.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>48347</p> <p>Based on review of personnel files, review of facility documentation, and staff interview, it was determined that the facility failed to employ a qualified registered dietician.</p> <p>Findings include:</p> <p>Review of dietitian job description revealed the clinical dietitian assesses the nutritional needs and dietary restrictions of the residents to develop and implement a plan of care to meet nutritional needs and maintain overall quality of life. Job descriptions and responsibilities include to complete assessments, chart reviews, develop an individualized nutrition care plan, nutrition focus physical exams, provide nutrition education counseling and support, review all monthly and weekly weights complete assessment and make modifications to nutrition plan of care as clinically indicated. Further review of the dietitians' responsibilities includes collaborate with inner disciplinary team members, consult with positions, assistant coordination of nutritional care services, monitor food service operations, perform all duties necessary and in accordance with the facility policy, understand and follow CMS guidelines and combines with the Department of health regulations. Requirements needed for the position of registered dietitian includes registered dietitian with the American Dietetic Association maintaining the statuses or requirement of the position.</p> <p>Review of the regional dietitian job description revealed the responsibilities and duties include to provide facility coverage during the absence of a registered dietician.</p> <p>Interview on May 14, 2025, at 10:53 a.m. with registered dietitian employee E5 confirmed that the dietitian has not completed the mandatory dietary LDN licensure exam.</p> <p>Interview with NHA employee E1 and DON employee E2 on May 15, 2025, confirmed that dietitian employee E5 has not completed the LDN licensure exam. Employee E5 has been working under the direct supervision of regional dietitian employee E 11.</p> <p>Review of resident records revealed that there was no indication that licensed dietician reviewed or consulted on any clinical documents.</p> <p>Review of Resident R1's clinical record of dietary notes, weight loss notation, nutritional assessment and care plan, revealed that resident dietician employee E5 was the only employee who reviewed and documented any notes pertaining to resident significant weight loss. There is no cosignature or indication that employee E 11 reviewed and or advised on the clinical record.</p> <p>28 Pa. Code 201.18(b)(3) Management</p> <p>28 Pa. Code 211.6(c) Dietary Services</p>		