

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Renaissance Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 220 Davenport St Italy, TX 76651	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards reviewed for food service safety in the reviewed 1 of 1 kitchen. The facility failed to ensure food safety by not consistently monitoring, discarding expired food, maintaining unsanitary kitchen equipment, and storage areas. These failures can place residents at risk for foodborne illness. Findings included: Observation in the kitchen on 9/08/2025 at 9:15 AM of the one refrigerator in the kitchen reflected the following: - Dannon Creamy Yogurt with an expiration date of 9-03-2025. Observation in the kitchen on 9/08/2025 at 9:23 AM of the one pantry reflected the following: - Marshmallows with an expiration date of 8-18-2025. - Wonder Hamburger buns with an expiration date of 8-18-2025. - Wonder Hot Dog buns with an expiration date of 8-28-2025. - Observation in the kitchen on 9/08/2025 at 9:30 AM of the one pantry reflected the following: - The ice machine scoop container had standing water in it with a brown dirt-looking substance in the water that was touching the scoop. - The bin containing serving utensils was dirty and had debris in it. An interview on 9/10/2025 at 1:23 PM with the DA revealed it was everyone's responsibility to check for out-of-date products in the kitchen. The DA said some items went out of date faster, and those items were checked more often. The DA said when a truck came in, they would put the old items in the front and the new items in the back. The DA said that it was everyone's responsibility to clean the kitchen. The DA said they signed off on the log when something was complete. The DA said the bin that kitchen utensils were in should be cleaned daily. The DA said they get in-service training on food safety and cleanliness. The DA said that residents could get sick if they were served outdated food. Interview on 9/10/2025 at 1:29 PM the CK said that it is everyone's responsibility to check for out-of-date food and clean the kitchen. The CK said if she sees a food item that is out-of-date, she tells the DM and throws the item away. The CK said that she puts the old items in front and the new items in the back. The CK said they sign in the log when they do a kitchen cleaning task. The CK said the bins that hold the utensils should be cleaned daily. The CK said the ice machine ice scoop container should be cleaned regularly. The CK said that residents could get sick if out-of-date food is served or if food is served with dirty utensils. Interview on 9/10/2025 at 1:37 PM the DM said that it is everyone's responsibility to clean the kitchen and check dates of food daily. The DM stated that new food goes in the back and old food in the front. The DM said that staff initial the log when a cleaning task is done. The DM stated that the bins that hold utensils and the ice scoop should be cleaned twice daily. In-service was completed 30 days ago on food safety and cleaning. The DM said that residents could get sick from outdated food or dirty kitchen utensils. Interview on 9/10/2025 at 2:15 PM the ADM stated that kitchen staff are expected to clean the kitchen daily and regularly check for out-of-date items. The ADM said that residents could get sick if they were to eat outdated food or food served with dirty utensils. Record review of the facility's food storage policy that was updated on 6-25-2025. Policy Interpretation and Implementation Food Services, or other designated staff, will maintain clean food storage areas at all times. Areas for cleaning dishes and utensils are located in a separate area from the food service line to ensure that a sanitary environment is maintained. Other opened containers must be dated and sealed or covered during storage.		

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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodations of resident's needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 1 of 5 residents (Resident #37) reviewed for resident rights. The facility failed to ensure Resident's #37's call light was within reach on 09/08/25. This failure could place residents at risk of needs not being met. Findings included: Record Review of Resident #37's face sheet dated 09/08/25 reflected the resident was a [AGE] year-old female admitted on [DATE]. Her diagnoses included ataxia (a neurological condition characterized by a lack of coordination and control of movements), chronic obstructive pulmonary disease (COPD) (a lung disease characterized by chronic respiratory symptoms and airflow limitation), atherosclerotic heart disease of native coronary artery (coronary artery disease) (heart disease involving the reduction of blood flow to the cardiac muscle due to a buildup of atheromatous plaque in the arteries of the heart), and dysphagia (difficulty in swallowing). Record Review of Resident #37's Quarterly MDS assessment dated [DATE] reflected Resident #37 was dependent on staff for eating, showering, and personal hygiene. The MDS reflected Resident #37 had a BIMS score of 03 which indicated Resident #37 was severely cognitively impaired. Record review of Resident #37's care plan dated 01/10/25 and revised on 02/11/25 reflected: Resident had an ADL self-care performance deficit. Goal: Resident #37 would maintain current level of function through the review date. [Resident #37] would improve current level of function through the review date. Interventions included: The resident was totally dependent on staff for repositioning and turning in bed as necessary. Record review of Resident #37's care plan dated 01/06/25 and revised on 01/10/25 reflected: Resident was a high risk for falls r/t imbalance, medications. Goal: Resident would not sustain serious injury through the review date. Interventions included: Maintain call light within reach. In an observation and interview on 09/08/25 at 11:01 AM, Resident #37 stated she was doing pretty good, and all staff treated her good. She stated she could not reach her call light where it was at that time. She stated she did not call anyone if she needed help, and she did not need any help. Observed Resident #37's call light cord which was running under Resident #37's fall mat and the call light was under the bed. In an interview on 09/08/25 at 11:08 AM, CNA C stated Resident #37 could use her call light, but she never did. She stated she always placed it by Resident #37 and told her to use it. She stated Resident #37 could not have reached the call light in the position it was in under the bed at that time. She stated she had been in-serviced on call light placement. She stated if a resident's call light was not within their reach, they may not have been able to tell staff what they needed or wanted, and they may have tried to get up to get what they needed or wanted and fell or hurt themselves. In an interview on 09/10/25 at 10:23 AM, the DON stated it was her expectation that all residents' call lights be within reach at all times. She stated staff had been trained on call light placement and ensuring residents had their call light within reach at all times. She stated if a resident's call light was out of their reach, it could have caused residents to not be able to get help if they required assistance. In an interview on 09/10/25 at 10:29 AM, the ADM stated it was his expectation that all residents' call lights be within reach at all times. He stated staff had been trained on call light placement and ensuring residents had their call light within reach at all times. He stated if a resident's call light was out of their reach, a resident may not have been able to get assisted in a timely manner or they may have had to resort to calling out. Record review of facility policy titled Resident Call System and dated October 2022 (reviewed 03/28/2023) reflected Policy: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Policy Interpretation and Implementation: 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. 6. Calls for assistance are answered as soon as possible. Urgent requests for assistance are addressed immediately.		

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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** Based on observation, interview, and record review the facility failed to ensure that drugs and biologicals used in the facility were stored properly for 1 of 1 medication storage rooms reviewed. The facility failed to ensure that expired medication administration supplies were removed from 1 of 1 medication storage rooms. This failure could place residents at risk for ineffective treatments and unnecessary invasive procedures. Use of these expired supplies could cause a central line medication catheter to dislodge, become infected, or need surgical replacement. Findings include: Observation on [DATE] at 3:00 PM of the medication storage room revealed the following medication administration supplies were expired: 1 Intravenous Administration Kit Expired [DATE] 1 Central line medication catheter Stabilizer Device Expired [DATE] 1 Central line medication catheter Stabilizer Device Expired [DATE] 4 Central line medication catheter Protection Disc (For Insertion Cite) Expired [DATE] 8 Central line medication catheter Dressing Kits Expired on the following dates: 1 on [DATE] 1 on [DATE] 1 on [DATE] 1 on [DATE] 3 on [DATE] In an interview with LVN-B on [DATE] at 12:28 PM she stated her expectation regarding expired medical supplies was that they should be discarded and given to the DON. She stated normally the nurses, and the medication aides were responsible for checking the supplies in the medication rooms, but they currently didn't have a medication aide, so it's just the nurses now. She stated the negative outcome to residents if expired supplies were used, the care could be non-therapeutic or make treatments non-effective, and the resident might not get better. In an interview with the DON on [DATE] at 12:41 PM she stated her expectation on expired medical supplies was that they be tossed in the trash. She stated that all the staff who have access to the medication room were responsible for checking for expired supplies. She stated the negative outcome to residents if expired supplies were used, was the integrity of the supplies could be compromised, and they could be non-effective for the resident's treatment. In an interview with RN-A on [DATE] at 01:11 PM she stated her expectation on expired medical supplies was that they should have been thrown into the trash. She stated that the nurses were responsible for checking for expired supplies in the medication room. She stated the negative outcome to residents if expired supplies were used was, the supplies may not work properly. She stated an example of this was using an expired central line dressing kit that may not be sterile any longer, so it could create a risk of infection for the resident. In an interview with the ADM on [DATE] at 1:29 PM, he stated his expectation on expired medical supplies was that they should be disposed of. He stated that central supply staff or nurses were responsible for checking the medication room for expired supplies. He stated the negative outcome to residents if expired supplies were used, was the supplies may not perform as they were intended to. He stated that if an expired sterile dressing was used, it could malfunction and cause an infection for a resident. A record review of facility policy titled, Storage of Medications, dated [DATE] with a review date of [DATE], reflected the following: The nursing staff is responsible for maintaining medication storage areas in a clean, safe, and sanitary manner. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 1 of 5 residents reviewed for wound care (Resident #4).LVN B failed to wash or sanitize her hands while going from a dirty to clean surface while performing wound care on 09/09/25 at 11:10 AM for Resident #4.This deficient practice placed residents at risk for cross contamination and the spread of infection.Record review of Resident #4's face sheet dated 09/09/25 reflected Resident #4 was a [AGE] year-old male with an admission date of 01/22/24. Resident #4's diagnoses included stage 4 pressure ulcer to coccyx ((tailbone) a triangular bone at the base of the spinal column), or stage 4 bedsore, (a severe wound that extends through all layers of skin into the underlying tissues, exposing muscle, bone, or tendon), dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), diabetes (a group of diseases that result in too much sugar in the blood), and peripheral vascular disease, also known as peripheral artery disease, is a condition that occurs when blood vessels narrow or become blocked, reducing blood flow to the body. Peripheral vascular disease can affect any blood vessel outside of the heart, but it most commonly affects the legs and feet). Record Review of Resident #4's Quarterly MDS assessment dated [DATE] reflected Resident #4 was dependent on staff for toileting and personal hygiene, required set-up or clean up assist with eating, and required substantial/maximal assistance with showering. The MDS reflected Resident #4 had a BIMS score of 13 which indicated Resident #4 was cognitively intact. Record review of Resident #4's care plan dated 06/09/25 and revised 08/18/25 reflected Focus: Wound #1 Stage 4 pressure ulcer to coccyx/sacrum area (tailbone) - admitted with, secondary to immobility/refusal of care. Goal: Resident was his own responsible party and would be educated and demonstrate understanding the importance of my compliance to individualized interventions for wound healing, and pressure injury/ulcer will show signs of healing and remain free from infection by/through review date. Interventions included: Administer treatments as ordered and monitor for effectiveness. Record review of Resident #4's care plan dated 06/09/25 and revised 08/18/25 reflected Focus: Stage 4 pressure injury/ulcer to right lower buttocks r/t Immobility, Refusal of Care - admitted with. Goal: Resident was his own responsible party and would be educated and demonstrate understanding the importance of my compliance to individualized interventions for wound healing, and pressure injury/ulcer will show signs of healing and remain free from infection by/through review date. Interventions included: Administer treatments as ordered and monitor for effectiveness. Record review of Resident #4's care plan dated 06/09/25 and revised 08/18/25 reflected Focus: Wound #1 Stage 4 pressure injury/ulcer to left heel r/t Immobility, Refusal of Care - admitted with. Goal: Resident was his own responsible party and would be educated and demonstrate understanding the importance of my compliance to individualized interventions for wound healing, and pressure injury/ulcer will show signs of healing and remain free from infection by/through review date. Interventions included: Administer treatments as ordered and monitor for effectiveness. Record review of Resident #4's clinical physician orders dated 08/25/25 reflected an order for Clean wound to sacrum with Dakin's 0.125% solution and apply Santyl and calcium alginate cut to fit wound bed and cover with dry dressing daily and prn soiled/loose dressing every evening shift. Record review of Resident #4's clinical physician orders dated 08/25/25 reflected an order for Clean wound to right ischium (lower buttock) with Dakin's 0.125% solution and apply Santyl and calcium alginate cut to fit wound bed and cover with dry dressing daily and prn soiled/loose dressing every evening shift. Record review of Resident #4's clinical physician orders dated 08/25/25 reflected an order for Clean wound to left heel with wc/ns and apply Santyl and calcium alginate cut to fit wound bed and cover with dry dressing daily and prn soiled/loose dressing every evening shift. In and observation on 09/09/25 at 11:10 AM, revealed LVN B performed wound care on Resident #4. LVN B washed her (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands and gathered her supplies. LVN B began wound care and removed the resident's dressing from the sacrum area. LVN B cleansed the area and then removed her dirty gloves. LVN B replaced her gloves without washing or sanitizing her hands. LVN B applied ointment and a new dressing to Resident #4's wound. LVN B then changed her gloves again without washing or sanitizing her hands and began wound care to resident right ischium. LVN B removed the dressing and cleansed the wound and removed her gloves. LVN B replaced her gloves, without washing or sanitizing her hands, and applied ointment and a new dressing to resident's wound. LVN B then changed her gloves without washing or sanitizing her hands and removed the dressing from Resident #4's left heel. LVN B cleaned the wound on resident's left heel and changed her gloves without washing or sanitizing her hands. LVN B applied ointment and a new dressing to the wound on the resident's left heel. LVN B removed her gloves and washed her hands. In an interview on 09/09/25 at 11:30 AM, LVN B stated she had not washed or sanitized her hands during the entire time she performed wound care for Resident #4. She stated she usually sanitized her hands when going from a dirty to clean surface and in between removing a dirty dressing and applying a new one, and she did not know why she had not because her sanitizer was in her pocket. She stated she had been in-serviced and trained on handwashing and infection control. She stated if hands were not washed or sanitized when going from a dirty to clean surface or during wound care when removing a dressing and applying and new one, it could have caused the infection to be re-introduced or the infection to spread onto the new dressing which was being applied to another wound. In an interview on 9/10/25 at 12:41 PM, the DON stated when performing wound care and changing gloves between the dirty and clean step, the staff should sanitize or wash their hands. She stated failure to sanitize could cause infections to spread and the nurses were responsible for doing that step. She stated the negative outcome to a resident if hands were not sanitized could be infections. In an interview on 9/10/25 at 1:11 PM, RN A stated hand hygiene should be done when changing gloves during wound care. She stated hand hygiene between the dirty and clean step was important to prevent the resident from getting infections. In an interview on 9/10/25 at 1:29 PM, the ADM stated he was not familiar with wound care steps, and he deferred to his DON for those types of questions. A record review of the facility policy titled, Handwashing-Hand Hygiene Policy and Procedure dated 3-2020 with a last revision date of 10-2020 reflected the following: Facility considers hand hygiene the primary means to prevent the spread of infections. Use an alcohol-based hand rub for the following situations: 1. Before and after contact with residents. 2. Before handling clean or soiled dressings, gauze pads, etc. 3. Before moving from a contaminated body site to a clean body site during resident care. 4. After handling used dressings.		