STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE HEALTH AND REHABILITATION CENTER LLC	**325 JERSEY STREET , TRENTON, New Jersey, 08611**

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F0000	INITIAL COMMENTS NJ Complaint # 423347, 2582208, 2619854, 2803914, 2967343, 2977903 Survey date: 4/15/26-4/21/26 Census:123 Sample size: 24 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		05/04/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for	F0812	Plan of Correction – F0812 1. Corrective Action for Identified Issues All identified food safety and sanitation concerns were corrected immediately at the time of observation or upon identification: Undated and unlabeled food items, including applesauce, macaroni, and burger patties, were discarded. Molded peppers were removed and discarded. Expired milk cartons in the fourth-floor pantry refrigerator were discarded. All food items stored directly on the floor were removed and placed on shelving at least six inches above the floor. All open food items were properly covered, labeled, and dated.	06/21/2026

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 reverse for further 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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F0812 SS = F	Continued from page 1 food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 04/15/2026 from 9:27AM to 10:41AM, the surveyor observed the following in the kitchen in the presence of the U.S. FOIA (b)(6) In the Stand Up/Cold Prep refrigerator, a partially empty jar of applesauce observed with no opened date or use by date. The U.S. FOIA acknowledged it should be dated. On the floor beside the ice machine, debris was observed on the floor. In the dry storage room, the surveyor observed two boxes containing single-serve cereal bowls stacked directly on the floor. The U.S. FOIA acknowledged the boxes should not be on the floor and relocated the boxes to the shelf unit. In the dry storage room, three boxes containing single-serve cereal bowls were not labeled with a received by date. The U.S. FOIA acknowledged the received by date was missing from the boxes. In the dry storage room, an opened box of enriched macaroni product was observed with no opened date or use by date. In the walk-in refrigerator in an uncovered cardboard box of green and red bell peppers, four green peppers at the top of the box were observed to be discolored and mottled. The U.S. FOIA stated they would dispose of them. In the walk-in freezer doorway, a used disposable glove was observed on the floor. In the walk-in freezer a box containing plastic bag of burger patties was observed opened to air with no opened date or use by date. Below the countertops a meat patty was observed on the floor against the wall. Components of the meat slicer including the blade cover and the tray on which the meat rests when	F0812	Continued from page 1 The ice machine and all affected kitchen and pantry areas were immediately cleaned and sanitized. Debris, including gloves and food items on the floor, was removed and proper sanitation was completed. The meat slicer components were cleaned, sanitized, and properly stored in a protected manner. The unknown substance in the pantry freezer and bins was removed and the area sanitized. The resident refrigerator was addressed: a thermometer was returned to the refrigerator unit, and a current temperature log was initiated and maintained daily by the Unit Manager or designee. Staff personal food items were removed from resident pantry areas, and staff were educated by the Director of Nursing or designee on use of the staff break room refrigerator. Resident refrigerators were inspected to ensure thermometers were present and temperature logs were in place and current 2. Identification of Other Areas with the Potential to be Affected All residents have the potential to be affected by the deficient practice. 3. Systemic Changes to Prevent Recurrence The facility implemented the following corrective measures: All dietary staff, nursing staff, will be re-educated on food safety standards, including proper labeling, dating, storage, and sanitation practices in accordance with facility policies by the Food Service Director, Dietary Manager, Director of Nursing, Environmental Services Director, or designee.	06/21/2026

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F0812 SS = F	Continued from page 2 slicing were observed on the table open to air on top of oven mitts. The [redacted] stated she was unsure if they needed to be covered with the slicer and then placed them under the cover with the meat slicer. On 04/17/2026 at 10:33 AM in the fourth-floor pantry refrigerator, the surveyor observed 2 cartons of milk that were frozen to the back of the refrigerator. The fourth-floor Unit Manager (UM) #1 stated that these items should not be frozen to the refrigerator. Licensed Practical Nurse (LPN) # 1 used a utensil to remove the milk cartons from the back of the refrigerator. The surveyor observed the cartons to have expiration dates of April 1 and April 7. LPN #1 confirmed the cartons of milk were expired and disposed of them. On 04/17/2026 at 11:04 AM, in the third-floor pantry freezer an unknown brown substance was observed on the bottom and on the door of the freezer. In the cabinet one white colored bin was observed with light brown colored particles at the bottom. On the shelf an unlabeled and undated take-out container was observed. On the same day at 11:11 AM, in an interview, LPN #2 stated that the take out containers were another staff member's food. LPN #2 further stated that the take out container should have been labeled and in the refrigerator. LPN #2 stated that the refrigerator is emptied once a week and unsure of how often it is cleaned. On 4/17/2026 at 11:13 with the permission of the resident and in the presence of LPN #2 the surveyor observed a resident's personal refrigerator. The surveyor observed that there was no thermometer in the refrigerator. When asked by LPN #2, the resident indicated that they had taken the thermometer out of the refrigerator and placed it in a drawer. At the same time, a temperature log with the month November written on it, was observed attached to the side of the resident's refrigerator. LPN #2 acknowledged that the temperature logs were not being completed. On the same date at 11:19 AM during an interview, UM #2 confirmed that only one resident in the facility had a personal refrigerator. UM #2 stated that nursing staff are responsible for maintaining and recording the temperature log of the refrigerator. On 04/17/2026 at 11:37 AM the surveyor observed a dark brown substance inside the ice machine, along top of the machine.	F0812	Continued from page 2 Cleaning schedules will be reviewed and revised by Food Service Director, Director of Nursing, Environmental Services Director, or designee, to include daily, weekly, and monthly cleaning responsibilities for kitchen, pantry, and ice machine areas, with assigned accountability. Nursing staff will be re-educated on their responsibility for monitoring pantry refrigerators, including removal of expired items, prohibition of staff food storage, temperature logs by Director of Nursing, Assistant Director of Nursing, or designee. . 4. Monitoring to Ensure Sustained Compliance Food Service Director, or designee will conduct ongoing audits, weekly for kitchen sanitation and food storage checks for four weeks..and monthly for two months. Audits will include verification of proper labeling, dating, food storage, sanitation practices, absence of expired food, and proper temperature monitoring. Any identified issues will result in immediate corrective action, including re-education. Audit findings will be reviewed monthly at the Quality Assurance and Performance Improvement meeting for three months as appropriate to ensure sustained compliance and to determine if further interventions are required.	06/21/2026

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F0812 SS = F	Continued from page 3 On 04/21/2026 at 9:41 AM during an interview the U. S. FOIA (b) (2)) stated that housekeeping should be cleaning the pantry monthly and all staff should monitor daily for old or expired food items. On the same date and time during an interview the U. S. FOIA (b) (2)) stated that staff should not store their personal food items in the pantry. A review the policy titled, "Receiving" revision date 2/2023, revealed under number 5, "All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation". The facility was unable to provide a policy specific to labeling and dating but did provide a Labeling and dating in-service provided to new hires with no date. The in-service titled "Labeling and Dating Inservice," under the section "Guidelines for Labeling and Dating" revealed, "All foods should be dated upon receipt before being stored". A review of the policy titled "Food Storage: Dry Goods" revision date 2/2023, revealed under the section "Procedures" number 1, "All items will be stored on shelves at least 6 inches above the floor." The policy further revealed under number 6, "Storage areas will be neat, arranged for easy identification and date marked as appropriate." A review of the policy titled "Food Storage: Cold Foods" revision date 2/2026, revealed under the section "Procedures" number 5, "All food will be stored wrapped or in covered containers, labeled and dated…" A review of the policy titled "Resident Refrigerators" revised 08/27/2024 revealed in the section, "Policy explanation and Compliance Guidelines" under number 2, "Maintenance or Designee shall record refrigerator temperatures weekly on a temperature log attached to the refrigerator." The policy further states "A thermometer shall remain in the refrigerator." A pantry policy was requested but not provided by the facility. NJAC 8:39-17.2(g)	F0812		06/21/2026
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F0584	Plan of Correction – F0584 1. Corrective Action for Identified Issues	06/21/2026

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F0584 SS = E	Continued from page 4 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the residents' living environment in a clean, sanitary, and homelike manner for 2 of 4 units (Second and Fourth Floor). The deficient practice was evidenced	F0584	Continued from page 4 All identified environmental and sanitation concerns were addressed immediately: Room [redacted]: The stained bathroom chair was removed, cleaned, and sanitized and replaced. The area was cleaned and disinfected. Room [redacted]: The damaged bathroom wall was repaired, patched, and repainted. Room [redacted]: The room was thoroughly cleaned and deodorized. All soiled linens were removed and replaced with clean linens. Third floor shower room: The wall patch was properly retiled, and the floor molding was repaired and secured appropriately. Room [redacted]: The damaged dresser was replaced. Room [redacted]: Peeling paint was repaired and repainted. Second floor shower room: The sink was cleaned and sanitized, removing all debris. 2. Identification of Other Areas with the Potential to be Affected All resident have the potential to be affected by the deficient practice. 3. Systemic Changes to Prevent Recurrence The facility implemented the following corrective measures: All housekeeping staff were re-educated on cleaning standards, including identification and immediate removal of stained or soiled items, and expectations for maintaining a clean and odor-free environment by Environmental Services Director or designee. Nursing staff was re-educated on their responsibility to report environmental concerns, including soiled	06/21/2026

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F0584 SS = E	Continued from page 5 by the following: During the initial tour on 04/15/2026 at 9:30 AM, surveyor #1 observed the following: Room [NJ Ex 6]: A chair in the bathroom had a brown stain on the seat. Room [NJ Ex 6]The bathroom wall had large scuff marks that penetrated through the drywall. Room [NJ Ex 6]A foul odor was present, and the unmade bed had stained sheets and pillowcases. [NJ Ex Order 26, 43] Shower Room: A patch in the tiled wall had not been retiled. Additionally, the floor molding was peeling off and was held in place with tattered blue tape, which was also peeling. During follow-up rounds on 04/20/2026 at 10:50 AM, surveyor # 1 observed: Room [NJ Ex 6]: A foul odor remained, and the bed was made with visible stains on the top blanket. Room [NJ Ex 6]The same chair remained in the bathroom with the same brown stain; an open, half-used roll of toilet paper was sitting on the chair. During an interview on 04/17/2026 at 11:35 AM with Surveyor #1, a [U. S. FOIA (b) (2)] stated that residents' bedding is changed every other day unless it requires more frequent changing. During an interview on 04/20/2026 at 11:00 AM with Surveyor #1, a [U. S. FOIA (b) (2)] stated they enter rooms several times a day to clean, specifically to sterilize the room, clean the bathroom, and empty the trash. When asked about the stained chair in Room [NJ Ex 6], the [U. S. F] stated, "It would be my responsibility to clean the chair if I saw it." During an interview on 04/20/2026 at 11:04 AM with Surveyor #1, the [U. S. FOIA (b) (2)]) stated that resident rooms are cleaned daily, including wiping high-touch areas, cleaning bathrooms, and sweeping/mopping floors. The [U. S. FOIA] noted that if furniture or surfaces are dirty, they	F0584	Continued from page 5 linens, odors, and damaged equipment, and to ensure timely linen changes based on resident need, not limited to a set schedule by the Director of Nursing, Assistant Director of Nursing or designee. Maintenance staff was re-educated on timely repair expectations, including proper methods for wall repair, painting, and fixture maintenance, and not using temporary fixes such as tape in resident care areas by Administrator or designee. Rounding processes will be revised to include weekly rounds by Director of Nursing, Director of Environmental Services, Maintenance Director or designee. Weekly room audits will be conducted for 4 weeks by housekeeping supervisor or designee, to maintain compliance with homelike and clean environment. 4. Monitoring to Ensure Sustained Compliance The Director of Environmental Services, Director of Nursing, or designee will conduct ongoing audits weekly environmental rounds on all units for four weeks. Biweekly audits for one month. Audit findings will be reviewed monthly at the Quality Assurance and Performance Improvement meeting for three months or as appropriate to ensure sustained compliance and to determine if further monitoring or interventions are required.	06/21/2026

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F0584 SS = E	Continued from page 6 should be cleaned. During an interview on 04/20/2026 with Surveyor #1, the U. S. FOIA (b) (2) stated that resident rooms and common areas are rounded on at least monthly. The U. S. FOIA stated that concerns are typically fixed immediately and that holes should be patched with sheetrock and repainted. The U. S. FOIA also confirmed the shower room patch should have been retiled and the floor molding should have been repaired rather than taped. On 04/15/2026 at 10:00 AM during tour of the low side of the NJ Ex Order 28 floor, Surveyor #1 observed the following: a dresser in room NJ Ex O with the wood veneer peeling exposing particle board, paint was peeling off of the wall under the window exposing the drywall in room NJ Ex Orde the sink in the low side shower room had multiple black and gray strands of hair in it. During an interview on 04/21/2026 at 9:46 AM, the U. S. FOIA (b) (2) stated that the bedside dresser in room NJ Ex Orde and the paint in room NJ Ex O were resolved yesterday. He furthered that the issues required quicker attendance. A review of the facility policy titled "Safe and Homelike Environment" revealed: "In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible." N.J.A.C. 8:39-31.4(f)	F0584		06/21/2026
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to	F0755	Plan of Correction – F0755 1. Corrective Action for Resident(s) Affected Controlled substance records for Resident #47 Resident #58 and Resident #69 were immediately audited and reconciled on NJ Ex Order 28, 4B1 Licensed nursing staff involved were immediately educated and in-serviced. All remaining controlled medications were physically counted and matched against declining inventory sheets and physician orders. The attending physician and consultant pharmacist were notified of discrepancies as indicated.	06/21/2026

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F0755 SS = E	Continued from page 7 meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to accurately account for the administration, disposition, and reconciliation of 3 controlled medications for 3 sampled resident (Resident #47, Resident #58 and Resident #69) identified upon inspection of 2 of 3 medication carts (second floor low-side cart and high-side cart). The evidence was as follows: On 4/15/2026 at 10:47 AM, the surveyor in the presence of the[U. S. FOIA (b) (2)]) inspected the second-floor high end medication cart. A review of the[NJ Ex Order 26,4(] located in the secured and locked[NJ Ex Order 26,] box revealed Resident 58's "Chain-of-Custody Record" (a declining inventory record) fo[NJ Ex Order 26, 4B1] did not match. The bag contained 7 bottles, six contained medication and one was empty. The "Chain-of-custody Record" had not been completed to indicate any doses had been administered. A further review of the[NJ Ex Order 26,] box revealed Resident #69's[NJ Ex Order 26, 4B1] use disorder, did not match the "Individual Patient's Controlled Drug Record". The medication box contained two films and the declining inventory sheet indicated there should be three films remaining. The[U. S. FOIA] stated she had administered the medications earlier and she had forgotten to sign the declining inventory sheets. The[U. S. FOIA] further stated the	F0755	Continued from page 7 An internal investigation was initiated regarding the[NJ Ex Order 26, 4B] discrepancy for Resident #47; no adverse resident outcomes were identified. Any identified documentation omissions were corrected at the time of discovery. On 04/16/2026, the facility conducted an audit of all controlled substances and sign out sheets in the medication carts. The audit included: Verification of medication counts Review of declining inventory sheets Comparison with active physician orders and electronic medical record documentation 2. Identification of Other Residents at Risk All residents receiving controlled medications have the potential to be affected by the deficient practice 3. Systemic Changes to Prevent Recurrence The Director of Nursing, Assistant Director of Nursing or designee, will reinforce its controlled substance management system as follows: Controlled Substance Removal and Documentation: Licensed nurses must sign the declining inventory sheet at the time of medication removal and document administration in the electronic medical record immediately after administration. Shift-to-Shift Narcotic Count: A full narcotic count is completed at every shift change by two licensed nurses. Both nurses must verify and sign the count. Any discrepancy must be reported immediately to the Unit Manager and Director of Nursing and investigated without delay. Medication Wasting:	06/21/2026

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F0755 SS = E	Continued from page 8 declining inventory sheet should be signed after the medication had been administered. On 4/15/2026 at 11:03 AM, the surveyor in the presence of the U. S. FOIA (b) (2)) inspected the NJ Ex Order 26, floor low-end medication cart. A review of the narcotics located in the secured and locked narcotic box and the declining inventory sheet, revealed Resident #47's NJ Ex Order 26, 4B1 count was incorrect. Resident #47's medication order was for NJ Ex Order 26, 4B1 to make a NJ Ex Order 26, 4B1 . The number of tablets remaining in the blister pack was nine. The declining inventory sheet also revealed there should be NJ Ex Order 26, 4B1 remaining, this would not be possible if the dose required two tablets for accurate medication administration. At that time the U. S. F acknowledged that the count could not be correct that if two tablets were administered at each dose, then the balance could not be an odd number of tablets such as nine, unless one tablet had been wasted. A review of the reverse side of the declining inventory revealed two tablets had been wasted and the U. S. FO again confirmed the count was not correct. The U. S. FOIA further stated she had not administered NJ Ex Order 26, 4B to Resident #47 that day. On 4/16/2026 at 12:30 PM, the surveyor interviewed the NJ Ex Order 26, floor U. S. FOIA (b) (2) who confirmed the nurses should have signed the declining inventory sheets when they removed the medications from the packaging and once administered, they should sign in the electronic medical record (EMR). When asked about the NJ Ex Order 26, 4B for Resident #47 he stated he was aware and had brought the information to the U. S. FOIA (b) (2) . On 4/20/2026 at 12:41 PM, the surveyor interviewed the U. S. FOIA (b) (2) who stated the nurses should sign out the controlled medications when they are removed from the packaging and once administered then sign off in the EMR. The U. S. FOIA (b) (2) confirmed the nurses had not followed the facility policy. The U. S. FOIA further stated they were currently investigating Resident #47's NJ Ex Order 26, 4B administration and discrepancy in documentation. A review of the facility's undated "Controlled Substance Administration and Accountability" policy included "All controlled substances obtained from a	F0755	Continued from page 8 All wasted or discontinued medications require two licensed nurse signatures and immediate documentation on the declining inventory sheet. Unit Managers or designee will perform weekly narcotic audits of each medication cart to verify accurate counts, proper documentation, and completion of shift-to-shift counts, for four weeks. Pharmacy Oversight: The consultant pharmacist will conduct monthly controlled substance record reviews, including reconciliation and documentation compliance. Staff Education all nurses will be re educated on proper completion of declining inventory sheets, real-time documentation, shift-to-shift count expectations, and discrepancy reporting procedures. Education will be provided by the Director of Nursing, Assistant Director of Nursing or designee. All education will be completed by 5/21/2026. 4. Monitoring to Ensure Sustained Compliance Unit Managers or designee will conduct weekly narcotic audits for four weeks. All findings will be documented on a narcotic audit tool and reviewed weekly by nursing leadership as appropriate. Audit findings will be reviewed monthly at the Quality Assurance and Performance Improvement meeting for three months as appropriate to ensure sustained compliance and to determine if further interventions are required.	06/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

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F0755 SS = E	Continued from page 9 non-automated medication cart or cabinet are recorded on the designated usage form… scheduled II controlled substances dispensed from the pharmacy for a patient-specific are recorded on the Controlled Drug Record supplied with the medication or other designated form as per facility policy…" NJAC 8:39- 29.2(d), 29.7(c)	F0755		06/21/2026
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit	F0582	Plan of Correction – F0582 Corrective Action for Resident #56 Resident #56 and or the resident representative were notified of the lapse in issuance of the Skilled Nursing Facility Advance Beneficiary Notice, Form CMS 10055. - Documentation of the notification was completed in the medical record. The U. S. FOIA (b) (2) reviewed the resident account to ensure there was no inappropriate billing related to the missed notice. No adverse financial impact to the resident was identified. 2. Identification of Other Residents with the Potential to be Affected All residents have the potential to be affected by the deficient practice. 3. Systemic Changes to Prevent Recurrence The business office manager provided education regarding Medicare Part A coverage, non-covered services, and potential financial liability. U. S. FOIA (b) (2) will be re-educated on requirements for issuing the Skilled Nursing Facility Advance Beneficiary Notice, Form CMS 10055, in accordance with federal regulations and facility policy by Administrator or designee. Responsibility for oversight of the notice process will be assigned to the U. S. FOIA (b) (2) or designee.	06/21/2026

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F0582 SS = D	Continued from page 10 or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN), Form CMS-10055, to 1 of 3 residents (Resident # 56) reviewed under Beneficiaries Task. The deficient practice was evidenced by the following: A review of Resident # 56's Electronic Medical Record revealed the resident was admitted with Medicare A as the primary payer source. A review of the Beneficiary Notification Review completed by the facility revealed that Resident # 56's Medicare Part A skilled services episode start date was 09/04/2025. The last covered day of Part A service was 12/1/2025. A review of the Beneficiary Notification Review revealed that the SNF ABN, Form CMS 10055 was not provided to the resident. No explanation was provided on the SNF Beneficiary Notification Review form. On 04/20/2026 at 10:43 AM during an interview with the surveyor, the facility's U. S. FOIA (b) (2) said that the U. S. FOIA (b) (2) at the time, did not know they had to issue a SNF ABN form. She said that originally "yes" was checked on the SNF Beneficiary Notification Review form but it was changed to "no" when it was discovered the Social Worker never sent the the SNF ABN form. A review of the facility policy titled, "Advance Beneficiary Notices" dated 05/07/2025 revealed under, "Explanation and Compliance Guidelines" that "The current CMS-approved version of the	F0582	Continued from page 10 All education will be completed by 5/21/2026. 4. Monitoring to Ensure Sustained Compliance The Administrator or designee will conduct Monthly audits of all Medicare Part A residents for two months to ensure compliance with regulations. Any identified issues will result in immediate corrective action, including re-education. Audit findings will be reviewed monthly at the Quality Assurance and Performance Improvement meeting for three months or as appropriate to ensure sustained compliance and to determine if further interventions are required.	06/21/2026

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F0582 SS = D	Continued from page 11 forms shall be used at the time of issuance to the beneficiary (resident or resident representative). Contents of the form shall comply with related instructions and regulations regarding the use of the form. a. For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), Form CMS-10055." N.J.A.C. § 8:39-4.1 (a) 8	F0582		06/21/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and review of other pertinent facility documents, it was determined that the facility failed to implement care consistent with the resident's care plan by failing to order and implement NJ Ex Order 26.4(b)(1) [redacted]. This deficient practice was observed for 1 of 1 resident (Resident #3) reviewed for NJ Ex Order 26, 4B1. The deficient practice was evidenced by the following: On 04/15/2026 at 12:12 PM during initial tour, Resident #3 was observed lying in their bed attached to an NJ Ex Order 26, 4B1 [redacted]. At that time, the surveyor observed no NJ Ex Ord [redacted] signage outside the resident's doorway. At the same time the surveyor observed Resident #3s identification sign at the top of the doorway with no colored mark next to his/her name. On 4/16/2026 at 1:27 PM the surveyor observed no NJ Ex Ord signage outside of the room of Resident #3. No evidence was observed to indicate Resident #3 was on NJ Ex Ord On 4/17/2026 at 10:51 AM, the surveyor observed and NJ Ex Ord sign to the right of Resident #3's doorway and a NJ Ex Order 26 visible on the identification sign at the top of the doorway. A review of Resident #3's Electronic Medical Record	F0658	Plan of Correction – F0658 1. Corrective Action for Resident(s) Affected Resident #3 was immediately assessed by the Infection Preventionist and nursing leadership upon identification of the deficient practice. A physician order for NJ Ex Order 26.4(b)(1) was obtained and entered into the electronic medical record on NJ Ex Order 26.4(b)(1) Appropriate NJ Ex Order 26.4(b)(1) signage was placed outside the resident's room, and a visual identifier NJ Ex Order 26.4(b)(1)) was applied per facility protocol. Nursing staff were immediately educated on the implementation of Enhanced Barrier Precautions, including the use of gown and gloves during high-contact care related to gastrostomy tube management. The care plan was reviewed and confirmed to align with the physician order and current infection prevention practices. 2. Identification of Other Residents at Risk All residents have the potential to be affected by the deficient practice. 3. Systemic Changes to Prevent Recurrence The facility will revise its Enhanced Barrier Precautions workflow process to ensure alignment between care plans, physician orders, and environmental identifiers: The Infection Preventionist and Director of Nursing or designee, will be responsible for initiating and verifying physician orders for Enhanced Barrier	06/21/2026

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F0658 SS = D	Continued from page 12 (EMR) revealed Resident #3's diagnoses that included but not limited to, NJ Ex Order 26, 4B1 [redacted] A review of Resident #3's EMR revealed no orders for Enhanced Barrier Precautions. A review of Resident #3's care plan revealed a Focus for NJ Ex Order 26.4(b)(1) initiated on [redacted]. The focus revealed a goal of [redacted] On 04/16/2026 at 1:30 PM during an interview with the U. S. FOIA (b) (2) stated, staff know that residents are on [redacted] by the [redacted] signage outside of the resident's doorway and by NJ Ex Order 26.4(b)(1) next to the resident's identification signage at the top of the doorway. The [redacted] indicated that she was unaware what the policy was for a resident care planned for [redacted] with no [redacted] order. On 4/17/2026 at 10:51 AM during a follow up interview with the [redacted] stated that if a resident is care planned for [redacted] they should have an order and a sign outside of the resident's doorway with the colored marking next to the resident identification sign. On 4/17/2026 at 1:03PM during an interview, the U. S. FOIA (b) (2) stated that residents with gastrostomy tubes should be on [redacted] The [redacted] further stated that once a resident is care planned for [redacted] they should have an order placed. The [redacted] stated that she was responsible for ensuring [redacted] orders are entered into the computer system. On 04/21/2026 at 9:41AM during an interview the U. S. FOIA (b) (2)) stated that both the U. S. FOIA (b) (2) will review resident orders and care plans to ensure accuracy. The [redacted] further stated the importance of ensuring that residents under [redacted] have the appropriate orders to maintain patient safety and for infection prevention purposes. A review of the policy titled "Enhanced Barrier Precautions" revised on 09/09/2025, revealed under number 2 "Initiation of Enhanced Barrier Precautions" under section b. "An order for enhanced barrier precautions will be obtained for residents with any of the following: … indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes…)"	F0658	Continued from page 12 Precautions at the time of care plan development or identification of an applicable condition. The Enhanced Barrier Precautions policy will be re-educated to all nursing staff by the Director of Nursing, Assistant Director of Nursing or designee. Requirement that all residents with Enhanced Barrier Precautions in the care plan must have a corresponding physician order Proper placement of signage and visual identifiers Infection prevention standards related to residents with potential portals of entry, including indwelling medical devices and wounds, with required use of gown and gloves during high-contact care and strict adherence to hand hygiene to prevent transmission of multidrug-resistant organisms Education will be provided by Director of Nursing, Assistant Director of Nursing, Infection Preventionist or designee. All education will be completed by 5/21/2026. 4. Monitoring to Ensure Sustained Compliance The Infection Preventionist or designee will conduct: Weekly reviews for four weeks Monthly audits for one month Audits will include: Residents who require Enhanced Barrier Precautions (for example: gastrostomy tubes, urinary catheters, wounds, central lines, and dialysis access) Verification of physician orders, care plans, and signage Any identified issues will result in:	06/21/2026

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F0658 SS = D	Continued from page 13 NJAC 8:39-27.1 (a)	F0658	Continued from page 13 Immediate correction Staff re-education Audit results will be reviewed monthly at the Quality Assurance and Performance Improvement meeting for three months to ensure compliance is met and as appropriate by the Administrator or designee to ensure sustained compliance and to determine if further interventions are required.	06/21/2026
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide [redacted] management that met professional standards of practice related to [redacted] management. Specifically, by giving [redacted] medication outside of the window of administration. This deficient practice was identified for 1 of 1 resident (Resident # 106) investigated for [redacted] The deficient practice was evidenced by the following: On 04/15/2026 9:43 AM the surveyor spoke to Resident #106 who stated that they received [redacted] medication late. A review of Resident #106's Admission Minimum Data Set (MDS) an assessment tool dated [redacted] reflected that they received routine [redacted] medication. A review of Resident #106's electronic medical record (EMR) revealed a diagnosis of but not limited to NJ Ex Order 26, 4B1 . A review of Resident #106's physician's orders located in the EMR revealed an order for NJ Ex Order 26, 4B1	F0697	Plan of Correction – F0697 1. Corrective Action for Resident #106 Resident #106 was immediately NJ Ex Order 26, 4B1 by licensed nursing staff. [redacted] level, effectiveness of current medication regimen, and timing of medication administration were reviewed. The attending physician was notified of the identified concern related to late medication administration. No new orders were issued at that time. The resident continues the current [redacted] management regimen with monitoring to ensure medications are administered within the acceptable time frame. The resident was interviewed regarding [redacted] control, and no ongoing unmet [redacted] needs were identified following intervention. 2. Identification of Other Residents with the Potential to be Affected All residents have the potential to be affected by the deficient practice. 3. Systemic Changes to Prevent Recurrence The facility has implemented the following corrective measures: All licensed nurses will be re-educated by the Director of Nursing or designee on medication administration standards, including the requirement that medications must be administered within one hour before or one hour after the scheduled time, unless otherwise clinically indicated. Education will include the importance of timely pain management, documentation accuracy, and	06/21/2026

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F0697 SS = D	Continued from page 14 NJ Ex Order 26, 4B1 to be given NJ Ex Order 26, 4B1 a day for NJ Ex Order 26, 4B1, and NJ Ex Order 26, 4B1 to be given NJ Ex Order 26, 4B1 A review of the "Medication Administration Audit" for NJ Ex Order 26, 4B1 revealed the NJ Ex Order 26, 4B1 were administered on the following dates and times: NJ Ex Order 26, 4B1 scheduled for 06:00 PM and given at 07:14 PM NJ Ex Order 26, 4B1 scheduled for 06:00 PM and given at 07:05 PM NJ Ex Order 26, 4B1 scheduled for 06:00 PM and given at 07:11 PM NJ Ex Order 26, 4B1 scheduled for 06:00 PM and given at 08:51 PM A review of the "Medication Administration Audit" for NJ Ex Order 26, 4B1 revealed the NJ Ex Order 26, 4B NJ Ex Order 2 were administered on the following dates and times: NJ Ex Order 26, 4B1 scheduled for 12:00 PM and given at 01:35 PM NJ Ex Order 26, 4B1 scheduled for 12:00 PM and given at 01:46 PM NJ Ex Order 26, 4B1 scheduled for 06:00 PM and given at 07:11 PM NJ Ex Order 26, 4B1 scheduled for 12:00 AM and given at 05:48 AM NJ Ex Order 26, 4B1 scheduled for 06:00 PM and given at 08:52 PM NJ Ex Order 26, 4B1 scheduled for 12:00 AM and given at 06:55 AM NJ Ex Order 26, 4B1 scheduled for 12:00 PM and given at 02:20PM During an interview with the surveyor on 04/16/2026 at 10:26 AM, the U. S. FOIA (b) (2) stated that medications can be administered one hour before and one hour after the scheduled time. The nurse	F0697	Continued from page 14 adherence to physician orders and facility policy titled "Pain Management." Medication pass schedules will be reviewed by the Director of Nursing or designee and adjusted, as needed, to ensure appropriate staffing and workflow to support timely administration. All education will be completed by 5/21/2026. 4. Monitoring to Ensure Sustained Compliance The Director of Nursing or designee will conduct audits of medication administration records for residents receiving scheduled pain medications. Unit Managers, Supervisors or designees will conduct weekly medication pass observations on all shifts for compliance for four weeks, The electronic medical record system will be utilized by the Director of Nursing or designee to generate reports identifying late medication administration for ongoing monitoring. Any identified issues will result in immediate corrective action, including re-education by the Director of Nursing or designee. Audits will include verification of administration times and documentation accuracy. Audit results will be reviewed monthly at the Quality Assurance and Performance Improvement meeting for three months to ensure compliance is met and as appropriate by the Administrator or designee to ensure sustained compliance and to de	06/21/2026

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F0697 SS = D	Continued from page 15 should then document that the medication was administered at the time of administration. During an interview with the surveyor on 04/21/2026 at 10:29 AM, the U. S. FOIA (b) (2) and the U. S. FOIA (b) (2) acknowledged that Resident #106 received his/her NJ Ex Orn medication late. A review of the facility policy titled, "Pain Management", with an implemented date of 10/01/2023, reflected that the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. NJAC 8:39-27.1(a)	F0697		06/21/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by:	F0761	Plan of Correction – F0761 1. Corrective Action for the Identified Issue The undated multi-dose vial of Tuberculin purified protein derivative located in the first-floor nursing office refrigerator was immediately removed and discarded. A new vial was obtained, properly labeled with the date opened, and stored in accordance with facility policy and professional standards of practice. The refrigerator used for medication storage was inspected to ensure all medications were properly labeled and stored appropriately. 2. Identification of Other Residents or Areas with the Potential to be Affected All residents have the potential to be affected by the deficient practice. 3. Systemic Changes to Prevent Recurrence The facility has implemented the following measures to ensure compliance: All licensed nurses will be re-educated on the facility policy titled "Labeling of Medications and Biologicals," including requirements for labeling multi-dose vials with the date opened and expiration date by the Director of Nursing or designee.	06/21/2026

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F0761 SS = D	Continued from page 16 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that all medications used in the facility were labeled and stored in accordance with professional standards of practice to preserve their integrity. This deficient practice was observed in 1 of 2 medication storage areas (first floor nursing office) inspected and was evidenced by the following: On 4/20/2026 at 12:29 PM, the surveyor in the presence of the U. S. FOIA (b) (2)), inspected the first-floor medication storage room. There was no medication refrigerator located in that room, the U. S. FOIA stated there was a refrigerator used to store medications located in the NJ Ex C -floor nursing office. On 4/20/2026 at 12:35 PM, the surveyor in the presence of the U. S. FOIA (b) (2) inspected the refrigerator in the first-floor nursing office. During inspection of the medication room refrigerator the surveyor observed an open, undated multi-use vial of Tuberculin Purified protein derivative (PPD) 5 TU/0.1ml (5 tuberculin units/0.1 milliliter), labeled "house stock". At that time the IP stated the vial of PPD should have been dated when it was opened and that once it was opened it was only "good for 30 days", then it should be discarded. Both the U. S. FOIA (b) (2) confirmed the NJ Ex C should have been dated when opened. A review of the facility's "Labeling of Medications and Biologicals" policy dated reviewed/revised 11/12/2024 included "All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices…Labels for multi-use vials must include: a. The date the vial was initially opened or accessed (needle punctured) b. All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial…" NJAC 8:39-29.4(h)	F0761	Continued from page 16 Education will reinforce that multi-dose vials must be discarded within twenty-eight days of opening unless otherwise specified by the manufacturer, provided by the Director of Nursing or designee. Medication storage practices, including proper refrigeration and separation of medications, will be reviewed with nursing staff by the Director of Nursing or designee. The Infection Preventionist or designee will receive additional education on infection control practices related to medication handling and storage by the Director of Nursing or designee. All education will be completed by 5/21/2026 4. Monitoring to Ensure Sustained Compliance The Director of Nursing or designee will conduct ongoing audits of medication storage and labeling practices Weekly for two months. . Any discrepancies identified will result in immediate corrective action, including re-education. Audit findings will be reviewed monthly at the Quality Assurance and Performance Improvement meeting for three months as appropriate to ensure sustained compliance and to determine if further interventions are required.	06/21/2026
F0804 SS = D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F0804	Plan of Correction – F0804 1. Corrective Action for Identified Issues	06/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE HEALTH AND REHABILITATION CENTER LLC	325 JERSEY STREET , TRENTON, New Jersey, 08611

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F0804 SS = D	Continued from page 17 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure standardized recipes were utilized to ensure food was prepared to conserve nutritive value and flavor. This deficient practice was identified for 2 of 2 observed lunch meals prepared and the evidence was as follows: On 04/16/2026 at 11:50 AM, Resident #9 stated that they were unsatisfied with the food they were served. Resident #9 stated that they did not receive the food listed on their ticket and the portions were small. On 04/17/2026 at 11:10 AM during the resident council meeting, 5 out of 5 members in attendance stated that the food was not appealing and was not palatable. On 4/16/2026 at 12:02 PM during an interview, the U. S. FOIA (b) (2) stated the menu is a set daily menu with a main entrée and alternate entrée. The U. S. FOIA further stated that the computer system generates the resident's meal ticket based on their diet order. The U. S. FOIA stated that any changes or any alternate are requested by the resident's nurse. The surveyor reviewed the week 3, "Week at a Glance" menu provided by the facility. The surveyor observed the main lunch meal for 04/17/2026 was lemon butter baked fish filet with roasted red skin potatoes, broccoli florets, dinner roll/bread and deluxe fruit salad. The alternate entrée was smothered turkey patty, seasoned rice and roasted beets. On 04/17/2026 at 12:46 PM the surveyor received a sample lunch tray with both the main entrée and the alternate lunch options. The alternate, smothered turkey patty meal did not contain the roasted beets listed on the menu but had a substitution of broccoli florets.	F0804	Continued from page 17 Immediate corrective actions were implemented: The food item containing a foreign object was discarded immediately. All dietary staff were re-educated on proper food handling and the requirement to wear NJ Ex Order 26.4(b)(1) at all times during food preparation and service. The Food Service Director reviewed preparation of all menu items to ensure meals are prepared in accordance with standardized recipes to support flavor, appearance, and nutritive value. The substituted menu item was addressed, and staff were instructed that all substitutions must be approved, documented, and accurately reflected on the meal ticket. Portion sizes were reviewed and corrected to ensure consistency with established serving standards. Resident #9 was interviewed, and dietary preferences were reviewed to promote meal satisfaction. 2. Identification of Other Residents with the Potential to be Affected All residents have the potential to be affected by this deficient practice. 3. Systemic Changes to Prevent Recurrence The facility implemented the following corrective measures: All dietary staff will be re-educated on the use of standardized recipes to ensure consistent preparation, flavor, and nutritive value. A formal test tray program will be implemented monthly for 3 months to evaluate temperature, taste, appearance, and accuracy. Dietary Staff will be re-educated on proper portion control and plating to ensure meals are attractive and consistent.	06/21/2026

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F0804 SS = D	Continued from page 18 At the same date and time, the surveyor placed a small portion of the fish filet onto a spoon to taste. The surveyor observed NJ Ex Order 26.4(b)(1) in the piece of fish. At the same date and time, two surveyors tasted the smothered turkey patty and were unable to consume. The surveyors noted that the flavor profile did not meet the expected standards of palatability. On 04/17/2026 at 1:16 PM in an interview with the U. S. FOIA, she confirmed that there was NJ Ex Order 26.4 the fish entrée. The U. S. FOIA further stated that there should not be NJ Ex O in the food. On the same date and time, the U. S. FOIA stated that she had not tasted the smothered turkey patty. The U. S. FOIA tasted the food upon the surveyors request and the U. S. FOIA stated that she thought it was good. The U. S. FOIA further stated that the turkey patty is premade, and the gravy is from a powder that water is added. The facility did not provide a policy related to the flavor or preparation of foods. NJAC 8:39-17.2(a); 17.4(a)(3)	F0804	Continued from page 18 Hair restraints are required at all times during food preparation and service, and compliance will be monitored. The dietary director or designee will review resident satisfaction through monthly resident council meetings and direct feedback through monthly food comittee. . All education will be completed by 5/21/2026. 4. Monitoring to Ensure Sustained Compliance The Administrator, Food Service Director, or designee will conduct ongoing monitoring. Monthly audits for 3 months. Any identified concerns will result in immediate corrective action, including re-education. Audits will include assessment of taste, appearance, portion size, menu accuracy, adherence to standardized recipes, and proper food handling practices. Audit findings will be reviewed monthly at the Quality Assurance and Performance Improvement meeting for three months as appropriate to ensure sustained compliance and to determine if further interventions are required.	06/21/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	Plan of Correction – F0880 1. Corrective Action for Resident #65 Resident #65 remained on NJ Ex Order 26.4(b)(1) as ordered. All nursing staff present at time of discovery 4/17/26 were re-educated on required infection control practices, including proper use of personal protective equipment upon room entry by the Director of Nursing, Assistant director of nursing. The resident's room signage was reviewed for clarity and accuracy to ensure it reflected required precautions. The Infection Preventionist confirmed that appropriate personal protective equipment supplies were available and accessible outside the resident's room. No further breaches were observed following immediate intervention.	06/21/2026

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F0880 SS = D	Continued from page 19 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880	Continued from page 19 2. Identification of Other Residents with the Potential to be Affected All residents have the potential to be affected by the deficient practice. 3. Systemic Changes to Prevent Recurrence The facility implemented the following corrective measures: All facility staff, will be re-educated on the facility policy titled “Transmission-Based Precautions,” with emphasis on donning personal protective equipment prior to room entry, regardless of the level of resident contact, by the Director of Nursing, Infection Preventionist, or designee. Education will include clarification that contact precautions require gown and gloves upon entry into the room or care area, not only during hands-on care. Signage for isolation precautions will be reviewed to clearly reflect required actions for staff and visitors by the Infection Preventionist or designee. Unit Managers, Supervisors or designees will be assigned responsibility to conduct routine rounds/audits to monitor compliance with infection control practices weekly for 4 weeks. All education will be completed by 5/21/2026. 4. Monitoring to Ensure Sustained Compliance The Director of Nursing and the Infection Preventionist or designee will conduct ongoing infection control audits Weekly reviews for four weeks, and monthly audits for 3 months focusing on isolation precaution compliance Any identified issues will result in immediate corrective action, including re-education. Audit findings will be reviewed monthly at the Quality Assurance and Performance Improvement meeting for three months as appropriate to ensure sustained compliance and to determine if further interventions are required.	06/21/2026

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F0880 SS = D	Continued from page 20 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that infection control practices were followed to prevent the potential NJ Ex Order 26.4(b)(1) for a resident on NJ Ex Order 26.4(b)(1). This deficient practice was evidenced for 1 of 10 residents (Resident # 65) reviewed under the Infection Control Task. The deficient practice was evidenced by the following: A review of Resident # 65's EMR revealed under orders that he/she has an NJ Ex Order 26, 4B1 The order clarifies that the NJ Ex Order 26.4(b)(1) type is NJ Ex Order 26. The order was started on NJ Ex Order 26, 4B1 A review of Resident # 65's Care Plan located in the EMR revealed the resident was on NJ Ex Order 26.4(b)(1). A review of Resident # 65's Care Plan located in the EMR revealed Resident # 65 had NJ Ex Order 26, 4B1 The Care Plan was last reviewed NJ Ex Order 26, 4B1 A review of Resident # 65's Care Plan revealed an intervention for but not limited to, "NJ Ex Order 26.4(b)(1) wear NJ Ex Order 2 and masks when changing NJ Ex Order 26.4(b)(1), Place NJ Ex Order 26.4(b)(1) in bags marked NJ Ex Order 26.4(b)(1) Give NJ Ex Order 26, 4B1 as ordered, Instruct visitors to wear disposable gloves and NJ Ex Orde when in residents room and to wash hands before leaving room." On 04/17/2026 at 10:53 AM while outside the room, the surveyor observed a sign that read, "For All Staff NJ Ex Order 26.4(b)(1) in addition to standard precautions". Further the sign read, "Before entering room/care zone Perform Hand Hygiene, Put on a gown, Wear gloves in accordance with standard precautions..." On that date and time, the surveyor observed CNA (Certified Nurses Aide) # 1 walk into the room and speak to Resident # 65. She did not apply NJ Ex Order 26 or	F0880		06/21/2026

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F0880 SS = D	Continued from page 21 gloves. Upon exiting the room, the surveyor asked if she needed to wear [NJ Ex Order 26] in that room. She replied that she did not have to wear [NJ Ex Order 26] unless she was doing care. During the interview, another CNA, CNA # 2 also entered the room without [NJ Ex Order 26] and began placing supplies on the bedside table in the room. When she exited the room, she informed the surveyor that they [staff] must wear [NJ Ex Order 26] when they are hands on with the resident. On the same date at 10:58 AM during an interview with the surveyor, the U. S. FOIA (b) (2) [redacted] told the surveyor that the staff only wears personal protective equipment (PPE) when they are doing hands-on care. On 04/17/2026 at 12:29 PM during an interview with the surveyor, the U. S. FOIA (b) (2) confirmed that Resident # 65 was on [NJ Ex Order 26.4(b)(1)]. When the surveyor asked what staff should do when entering that room, the U. S. FOIA (b) (2) replied, that for contact, there is a bin for that room, and it will have PPE. She clarified that before staff go into the room they have to wear it. A review of the facility policy titled, "Transmission-Based (Isolation) Precautions" dated 05/16/2023 revealed, "d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination…" N.J.A.C. § 8:39-19.4(a)	F0880		06/21/2026
F0925 SS = D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain an environment free of pests. The deficient practice was identified by observation of a live pest on 1 of 4 floors (2nd Floor) in the facility. The deficient practice was evidenced by the following: On 04/16/2026 at 10:40 AM while touring the 2nd	F0925	Plan of Correction – F0925 1. Corrective Action for Identified Issue The live insect observed on the second floor was immediately removed and disposed of. The area was cleaned and inspected by Environmental Services. The pest was documented in the pest control log. Pest control vendor conducted an inspection and treatment of the affected area, including the second-floor nursing station and surrounding locations. No additional pests were observed at that time. 2. Identification of Other Areas with the Potential to be Affected All residents have the potential to be affected by the	06/21/2026

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F0925 SS = D	Continued from page 22 floor in the hallway near the nurses station, the surveyor observed a brown insect crawling across the wall near the hand rail. At that time, the [redacted] also observed the insect when the surveyor brought it to his attention. He then used a disposable glove to dispose of the insect. The [redacted] informed the surveyor that he will document the occurrence in the "Pest Control Log". On 04/20/2026 at 12:55 PM during an interview with the surveyor, the [redacted] said that pest control services are scheduled biweekly. Further, he said they have had the company come in to make a more in-depth treatment. When the surveyor asked if there is an ongoing issue with insects, the [redacted] said they try to follow-up with residents in their rooms. He said when we become aware of rooms, pest control treats those specific rooms. A review of the facility-provided invoices from the pest control company for March of 2026, revealed that the facility has been treated for cockroaches. A review of the facility policy titled, "Pest Control Program" dated 04/02/2025 revealed that, "It is the guideline of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents." The policy defined an "Effective pest control program" as, "measures to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitos, flies, mice and rats)". N.J.A.C. § 8:39-31.5	F0925	Continued from page 22 deficient practice. 3. Systemic Changes to Prevent Recurrence Any areas identified as high risk will be logged in pest control binder and will be treated by the licensed pest control provider. All staff will be re-educated on reporting of any pest sightings and proper documentation in the pest control log by the Director of Nursing or designee. Environmental Services staff will be re-educated on enhanced cleaning practices, including prompt removal of trash, food debris, and clutter that may attract pests by the Environmental Services Director or designee. The Administrator or designee will oversee coordination with the pest control vendor to ensure timely and effective response to any identified concerns. Including target projects for specific areas or rooms. All education will be completed by 5/21/2026. 4. Monitoring to Ensure Sustained Compliance The Maintenance Director, Environmental Services Director or designee will conduct ongoing monitoring ,Weekly environmental rounds for four weeks, and monthly for 1 month focusing on pest control and sanitation Any identified issues will result in follow up corrective action, including re-education. Audit results will be reviewed monthly at the Quality Assurance and Performance Improvement meeting for three months to ensure compliance is met and as appropriate by the Administrator or designee to ensure sustained compliance and to determine if further interventions are required.	06/21/2026

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S0000	Initial Comments NJ Complaint #2803914 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		05/04/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 21 out of 21 day shifts out of day shifts reviewed, as evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every 8 residents for the day shift.	S0560	Plan of Correction – S0560 1. Corrective Action for Identified Issue Nursing leadership, including the Director of Nursing,staffing coordinator or designee, will review daily staffing assignments to ensure adequate coverage based on census and resident acuity. The Staffing Coordinator was re-educated on New Jersey minimum staffing requirements to ensure accurate scheduling moving forward. Facility has contracted with new agency to assist with staffing requirements. 2. Identification of Other Residents with the Potential to be Affected All residents have the potential to be affected by the deficient practice. 3. Systemic Changes to Prevent Recurrence A staffing oversight process was implemented to ensure daily review of staffing levels prior to each shift by the Director of Nursing or designee and	06/21/2026

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

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S0560	Continued from page 1 One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the week of Complaint staffing from 03/08/2026 to 03/14/2026, the facility was deficient in CNA staffing for residents on 7 of 7-day shifts as follows: -03/08/26 had 12 CNAs for 120 residents on the day shift, required at least 15 CNAs. -03/09/26 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs. -03/10/26 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -03/11/26 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -03/12/26 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -03/13/26 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -03/14/26 had 11 CNAs for 121 residents on the day shift, required at least 15 CNAs. For the 2 weeks of staffing prior to survey from 03/29/2026 to 04/11/2026, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -03/29/26 had 11 CNAs for 127 residents on the day shift, required at least 16 CNAs. -03/30/26 had 13 CNAs for 127 residents on the day shift, required at least 16 CNAs. -03/31/26 had 12 CNAs for 127 residents on the day shift, required at least 16 CNAs.	S0560	Continued from page 1 Staffing Coordinator or designee. The facility increased recruitment efforts, including job postings, open interviews, referral incentives, and partnerships with staffing agencies to maintain adequate Certified Nurse Aide staffing levels. Which is overseen by Human Resource director. Staffing coordinator, Director of Nursing, Assistant director of Nursing were re-educated on New Jersey staffing requirements, by administrator or designee. A contingency plan was implemented requiring call-offs to be attempted to replace prior to the start of shift to maintain required staffing ratios. Overtime and incentive programs were implemented to promote staff retention and ensure adequate coverage. Working with local Certitied nurse aide school to provide classes, and opportunities for recruitment. 4. Monitoring to Ensure Sustained Compliance The Administrator or designee and Director of Nursing or designee will conduct weekly review of staffing schedules for four weeks ,Weekly staffing audits for an additional month. Audit findings will be reviewed monthly at the Quality Assurance and Performance Improvement meeting for three months as appropriate to ensure sustained compliance and to determine if further interventions are required.	06/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061112	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0560	Continued from page 2 -04/01/26 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/02/26 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/03/26 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/04/26 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/05/26 had 9 CNAs for 126 residents on the day shift, required at least 16 CNAs. -04/06/26 had 11 CNAs for 126 residents on the day shift, required at least 16 CNAs. -04/07/26 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -04/08/26 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -04/09/26 had 13 CNAs for 128 residents on the day shift, required at least 16 CNAs. -04/10/26 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/11/26 had 10 CNAs for 124 residents on the day shift, required at least 15 CNAs. During an interview on 04/17/2026 at 9:01 AM with the surveyor, the staffing coordinator said she was aware of the certified nursing assistant staffing requirements. She stated that the facility meets the requirements. Review of the facility policy titled, "Nursing Services and Sufficient Staff", reviewed on 02/05/2025, reflected that the facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all resident in accordance with resident care plans: a except when waived, licensed nurses: and b. other personnel, including but not limited to nurse aides. The policy also reflected that it is a guideline of this facility to provide sufficient staff with appropriate competencies and the skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual	S0560		06/21/2026

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S0560	Continued from page 3 plans of care. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment.	S0560		06/21/2026
S1680	Mandatory Nurse Staffing CFR(s): 8:39-25.2(b)(1)&(2) (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of the Supplementary Nurse Staffing Report for the weeks of 03/29/2026 to 04/14/2026, it was determined that the facility failed to provide minimum staffing levels for licensed staff	S1680	Plan of Correction -S1680 Corrective Action for Identified Issue A review of licensed nursing staffing schedules will be conducted by staffing coordinator and Director of Nursing or designee to ensure compliance with the required hours per resident per day, including base hours and additional acuity-based services. Additional licensed nurses will be attempted to be scheduled, and agency licensed nurses will be attempted to be secured to meet required staffing hours. The Director of Nursing or designee and Staffing Coordinator or designee will review daily staffing levels and adjusted assignments to ensure adequate licensed nurse coverage based on census and resident acuity. 2. Identification of Other Residents with the Potential to be Affected All residents can be affected by the deficient practice. 3. Systemic Changes to Prevent Recurrence The facility implemented the following corrective measures: Staffing schedules will be reviewed daily by the Director of Nursing or designee and Staffing Coordinator or designee. To ensure proper staffing requirements are met. Recruitment efforts were enhanced to increase licensed nurse staffing, including partnerships with staffing agencies, recruitment incentives, and open interviews. And will be overseen by Human resources director.	06/21/2026

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S1680	Continued from page 4 on 11 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 03/29/26 Required Staffing Hours: 425.50 -03/29/26 had 376 actual staffing hours, for a difference of -49.50 hours. -03/30/26 had 424 actual staffing hours, for a difference of -1.50 hours. -03/31/26 had 416 actual staffing hours, for a difference of -9.50 hours. -04/01/26 had 424 actual staffing hours, for a difference of -1.50 hours. -04/02/26 had 416 actual staffing hours, for a difference of -9.50 hours. -04/03/26 had 329 actual staffing hours, for a difference of -33.50 hours. -04/04/26 had 360 actual staffing hours, for a difference of -65.50 hours. For the week of 04/05/26 Required Staffing Hours: 421 -04/05/26 had 344 actual staffing hours, for a difference of -77 hours. -04/06/26 had 400 actual staffing hours, for a difference of -21 hours. -04/10/26 had 408 actual staffing hours, for a difference of -13 hours. -04/11/26 had 368/ actual staffing hours, for a difference of -53 hours. During an interview on 04/17/2026 at 9:01 AM with the surveyor, the staffing coordinator said that she staffs nurses according to resident acuity, especially on the second floor with the high acuity residents. Review of the facility policy titled, "Nursing Services and Sufficient Staff", reviewed on 02/05/2025, reflected that the facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all resident in accordance with	S1680	Continued from page 4 All administrative staff involved in staffing will be re-educated on New Jersey licensed staffing requirements to include, director of nursing, assistant director of nursing, unit managers, staffing coordinator, by the Administrator or designee. 4. Monitoring to Ensure Sustained Compliance The Administrator or designee and Director of Nursing or designee will conduct weekly review of licensed staffing hours for four weeks ,biweekly audits for an additional one month. Audit findings will be reviewed monthly at the Quality Assurance and Performance Improvement meeting for three months as appropriate to ensure sustained compliance and to determine if further interventions are required.	06/21/2026

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S1680	Continued from page 5 resident care plans: a except when waived, licensed nurses: and b. other personnel, including but not limited to nurse aides. The policy also reflected that it is a guideline of this facility to provide sufficient staff with appropriate competencies and the skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment.	S1680		06/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 07/17/2026 in relation to the 04/21/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061112	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 07/17/2026 in relation to the 04/21/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315235	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 4/15/26 and 4/16/26. Riverside Health And Rehabilitation Center was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.	K0000		05/04/2026
K0211 SS = F Bldg. 01	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 4/15/26 and 4/16/26, in the presence of the U. S. FOIA (b) (2), it was determined the facility failed to ensure means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in case of fire or other emergency in accordance with NFPA 101: 2012 Edition, section 7.1.10, 7.2. This deficient practice had the potential to affect all residents and was evidenced by the following: 1) Observations on 4/15/26 at 11:25 AM of the central stairway revealed; the stairway served the 4 floors and basement with the level of exit discharge, exit door to outside on the first floor landing. When the exit door to outside on the first floor was tested it was excessively hard to open. In an interview at the time, the U. S. FOIA (b) (2) and	K0211	Life safety K0211-means of egress-general Central exit door to outside located on first floor stairwell. Door was adjusted to open and close smoothly. Fourth floor single cross corridor exit near room 409 leading to exit. Corridor is protected, All doors leading to exit were fixed so that they close and latch. All missing ceiling tiles were replaced for all the rooms. Third floor single cross corridor exit near room 309 leading to exit. Corridor is protected, All doors leading to exit were fixed so that they close and latch. All missing ceiling tiles were replaced for all the rooms. second floor single cross corridor exit near room 209 leading to exit. Corridor is protected, all doors leading to exit were fixed so that they close and latch. All missing ceiling tiles were replaced for all the rooms. -All residents can be affected by the deficient practice.	06/21/2026

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 reverse for further 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.

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K0211 SS = F Bldg. 01	Continued from page 1 U. S. FOIA (b) (2)) confirmed the observation, and the MS stated the door was hitting on the sound alarm device. 2) Observations on 4/15/26 at 11:45 AM of the 4th floor corridor revealed a single cross corridor exit door by room 409 that was marked as an EXIT with delayed egress signage. Further observations showed the path of egress through the closed area led to a stairway to exit down and out of the building. The corridor in the closed area was not protected from hazardous combustible storage in the unoccupied rooms, many of the rooms were filled with garbage and furniture and the doors were open. Additionally, many of the open rooms were missing ceiling tile leaving the smoke compartment open to the attic space. 3) Observations on 4/16/26 at 11:58 AM of the 3rd floor corridor revealed a single cross corridor exit door by room 309 was marked as an EXIT with delayed egress signage. Further observations showed the path of egress through the closed area corridor led to a stairway to exit down and out of the building. The corridor in the closed area was not protected from hazardous combustible storage in the unoccupied rooms, many of the rooms were filled with garbage and furniture and the doors were opened, missing hardware to keep closed and latch or the door was missing. Additionally, some of the open rooms were missing ceiling tiles leaving the smoke compartment open to the attic space. 4) Observations on 4/16/26 at 2:15 PM of the 2nd floor corridor revealed a single cross corridor exit door by room 209 was marked as an EXIT with delayed egress signage. Further observations showed the path of egress through the closed area led to a stairway to exit down and out of the building. The exit corridor in the closed area was not protected from hazardous combustible storage in the unoccupied rooms, many of the rooms were filled with garbage and furniture and the doors were: opened, missing hardware to keep closed and latch or the door was missing. Additionally, some of the open rooms were missing ceiling tiles leaving the smoke compartment open to the attic space. In interviews at the times, the U. S. FOIA (b) (2) confirmed the observations. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. N.J.A.C. 8:39 - 31.2(e)	K0211	Continued from page 1 - An audit on the exit pathways was performed to ensure compliance, and was incorporated as part of ongoing maintenance checks to ensure all affected pathways to exit are in compliance. U.S. FOIA (b)(6) was educated by administrator to make sure this will be done. Education was completed by 5/22/26. - maintenance director or designee will audit all the exit pathways, monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	06/21/2026

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K0222 SS = F Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed	K0222	Life safety KO222-Egress doors 1-fourth floor south side stairway exit door by room 419 will be repaired and tested to ensure delay release will operate correctly. 2- fourth floor cross corridor exit fire door by room 409,pull to open, will be repaired and tested to ensure delay release will operate correctly. 3-- third floor cross corridor exit fire door by room 309,pull to open, will be repaired and tested to ensure delay release will operate correctly. 4- second floor center stairway exit door across from room 207, will be repaired and tested to ensure delay release will operate correctly. 5-second floor south stairway exit by room 219 will be repaired and tested to ensure delay release will operate correctly. -All residents can be affected by deficient practice. -An audit of all the exit doors will be performed by maintenance director or designee to ensure compliance, and will be incorporated as part of ongoing maintenance checks to be done monthly, then quarterly as appropriate. The U.S. FOIA (b)(6) [redacted] will be educated by administrator to ensure compliance. Education will be completed by 5/22/26. - maintenance director or designee will audit all the exit doors, monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	06/21/2026

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K0222 SS = F Bldg. 01	Continued from page 3 in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 4/15/26 and 4/16/26, in the presence of the [U. S. FOIA (b) (2)], it was determined the facility failed to ensure delayed egress locking systems were operational in accordance with NFPA 101:2012 Edition, Section 7.2.1.6.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 4/15/26 and 4/16/26 of the exit door delayed egress locking systems revealed, the following delayed egress exit hardware did not work when tested: 4th floor south side stairway exit door by room 219. 4th floor cross corridor exit fire door by room 409, pull to open. 3rd floor cross corridor exit fire door by room 309, pull to open. 2nd floor center stairway exit door across from room 207. 2nd floor south side stairway exit door by room 219. In interviews at the times the [U. S. FOIA (b) (2)] confirmed the observations and tests. The facility's [U. S. FOIA (b) (2)] was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. 8:39-31.2(e)	K0222		06/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315235	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

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K0291 SS = F Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on observation, interview and record review on 4/15/26 and 4/16/26, in the presence of the U. S. FOIA (b) (2), it was determined the facility failed to ensure emergency lighting systems were tested monthly and annually in accordance with NFPA 101:2012 Edition, Section 7.9, 7.9.3, 7.9.3.1 to 7.9.3.1.3. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations during facility tours on 4/15/26 between 9:24 AM and 12:07 PM and 4/16/26 between 2:57 PM and 3:30 PM revealed the facility had emergency lighting stations throughout the facility. Record review on 4/16/26 of the Life Safety Code Inspection, Test and Maintenance reports revealed there was no report for the monthly and annual emergency light testing. In an interview at the time, the U. S. FOIA (b) (2) confirmed the record review and stated the U. S. FOIA (b) (2) walked out. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. N.J.A.C. 8:39 - 31.2(e)	K0291	Life Safety K0291-Emergency lighting -Emergency lighting systems were tested/monitored monthly and annually, and the results maintained to show proof of testing. -All residents can be affected by deficient practice. -maintenance director or designee will continue to perform an audit monthly, then quarterly to ensure compliance with emergency lighting, and will be incorporated in logs to show proof that it was done. Administrator or designee educated the U.S. FOIA (b)(6) to ensure compliance. Education was completed by 5/22/26. - maintenance director or designee started to audit compliance with emergency lighting, monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	06/21/2026
K0321 SS = F Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and	K0321	Life Safety K0321-hazaradous Areas enclosure -laundry room corridor doors by the washers will be adjusted to close as per regulation. -single kitchen door will be adjusted to close as per regulation. -the maintenance shop door will be repaired to have a self closing device. Bolt lock to be removed, and positive latching installed.	06/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315235	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/21/2026**

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K0321 SS = F Bldg. 01	Continued from page 5 doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and interview on 4/15/26, in the presence of the [redacted], it was determined the facility failed to ensure hazardous area doors were self closing or automatic closing and positive latched in accordance with NFPA 101:2012 Edition, Section 19.3.2, 19.3.2.1.3. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 9:58 AM of the laundry room corridor door by the washers revealed, the door was attached to a automatic hold open device. When tested by releasing the door from the device the door did not close into its frame, it made contact on the fixed door leaf of the 2 door system and stopped. Observations at 10 AM revealed the single kitchen door did not close all the way into its frame when tested. It stopped at the door frame.	K0321	Continued from page 5 -basement medical supply storage room, strike to be installed to allow for positive latching. -basement medical supply storage room by elevator 1, strike plate will be adjusted to latch -All residents can be affected by deficient practice. -An audit of all hazardous area enclosures will be performed by maintenance director or designee to ensure compliance, and will be incorporated as part of ongoing maintenance checks to be done monthly, then quarterly as appropriate. The [redacted] will be educated by administrator or designee to ensure compliance. Education will be completed by 5/22/26. - maintenance director or designee will audit all hazardous area enclosures, monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	06/21/2026

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K0321 SS = F Bldg. 01	Continued from page 6 Observations at 10:15 AM of the maintenance shop door revealed the door was not equipped with a self closing device and had a bolt lock not positive latching hardware. Observations at 10:17 AM of the basement medical supply storage room revealed, the room was greater than 50 square feet and contained combustible storage. The double doors had an operational leaf that had a self-closer but had no strike on the latching hardware. Observations at 10:35 AM of the basement medical supply storage room by elevator 1 revealed, the room was greater than 50 square feet and contained combustible storage. The double doors had an operational leaf that had a self-closer but did not close and latch when tested because the strike plate was loose. In interviews at the times the U. S. FOIA (b) (2) and U. S. FOIA (b) (2) confirmed the observations, and the U. S. FOIA (b) (2) stated the fire Marshall identified some of the same doors. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. N.J.A.C. 8:39 - 31.2(e)	K0321		06/21/2026
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.	K0324	Life Safety K0324-cooking facilities -Kitchen suppression system was inspected semi annually, and monthly owners inspection was and will continue to be performed monthly. -All residents can be affected by deficient practice. -maintenance director or designee will continue to perform an audit monthly, then quarterly to ensure compliance with cooking facilities,and ensure monthly and semi annual inspections will be completed. And will be incorporated in logs to show proof that it was done. Administrator or designee will educate the U.S. FOIA (b)(6) to ensure compliance. Education will be completed by 5/22/26. - maintenance director or designee will audit	06/21/2026

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K0324 SS = F Bldg. 01	Continued from page 7 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation, interview and record review on 4/15/26 and 4/16/26, in the presence of the U. S. FOIA (b) (2) and U. S. FOIA (b) (2), it was determined the facility failed to ensure the kitchen suppression system was inspected semiannually and that the monthly owners inspection was performed in accordance with NFPA 96 2010 Edition. and NFPA 17A. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 4/15/26 of the kitchen suppression system inspection tags on the wet chemical tank and system manual activation device revealed the last inspection was December 2025, further review of the backs of both tags showed the monthly inspection rows were blank. In an interview at the time, the U.S.F.D stated the contracted service does all the inspections on the kitchen suppression system which are semiannual, they don't do a monthly owners inspection. Record review on 4/16/26 of the semiannual kitchen suppression reports revealed, the last report was dated 12/18/25 and the previous inspection report was dated 12/4/24, that was 12 months without a semiannual inspection in-between. No further report was provided. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. N.J.A.C. 8:39 - 31.2(e) NFPA 96, 17A	K0324	Continued from page 7 compliance with cooking facilities to ensure monthly and semi annual inspections we be completed, monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	06/21/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K0345	Life Safety K0345-Fire alarm system-testing and maintenance -Fire alarm smoke sensitivity testing was performed as per regulations, and records kept of all inspections.	07/10/2026

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K0345 SS = F Bldg. 01	Continued from page 8 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on interview and record review on 4/16/26, in the presence of the U. S. FOIA (b) (2), it was determined the facility failed to ensure fire alarm smoke detector sensitivity testing was performed in accordance with NFPA 72: 2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: Record review of the provided fire alarm inspection, testing and maintenance reports revealed there was no documentation that the fire alarm smoke detector sensitivity testing was performed. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. N.J.A.C. 8:39 - 31.2(e) NFPA 72	K0345	Continued from page 8 -All residents can be affected by deficient practice. -maintenance director or designee has started an audit monthly, then quarterly to ensure compliance with fire alarm smoke sensitivity testing, and will be incorporated in logs to show proof that it was done. Administrator or designee has educated the U.S. FOIA (b)(6) to ensure compliance. Education was completed by 5/22/26. - maintenance director or designee started audit compliance with fire alarm smoke sensitivity testing monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	07/10/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K0353	Life Safety K0353- sprinkler system maintenance and testing -fire sprinkler system, fire pump will tested/inspected monthly as per regulation, and records kept. -All residents can be affected by deficient practice. -maintenance director or designee will perform an audit monthly, then quarterly to ensure compliance with fire sprinkler systems, fire pump, and will be incorporated in logs to show proof that it was done. Administrator or designee will educate the U.S. FOIA (b)(6) to ensure compliance. Education will be completed by 5/22/26. - maintenance director or designee will audit all compliance with fire sprinkler systems,fire pump monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report	06/21/2026

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K0353 SS = F Bldg. 01	Continued from page 9 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on interview and record review on 4/16/26, in the presence of the[U. S. FOIA (b) (2)], it was determined the facility failed to ensure the fire sprinkler system fire pump was tested and inspected monthly in accordance with NFPA 25: 2011 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the fire sprinkler system inspection testing and maintenance documents revealed there was no monthly testing and inspection record for the electric fire pump. In an interview at the time the[U. S. FOIA (b) (2)] confirmed the record review. The facility's[U. S. FOIA (b) (2)] was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. N.J.A.C. 8:39 - 31.2(e) NFPA 25	K0353	Continued from page 9 results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	06/21/2026
K0531 SS = F Bldg. 01	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)	K0531	Life Safety K0531-Elevators -Firefighter service will be tested monthly by elevator company , as part of the monthly checks for elevators #1,#2, and #3. And recorded to show proof. -All residents can be affected by deficient practice. -maintenance director or designee will perform an audit monthly, then quarterly to ensure compliance with firefighter service, being tested for all 3 elevators. and will be incorporated in logs to show proof that it was done. Administrator or designee will educate the[U.S. FOIA (b)(6)] to ensure compliance. Education will be completed by 5/22/26. - maintenance director or designee will audit compliance with firefighter service monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if	06/21/2026

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K0531 SS = F Bldg. 01	Continued from page 10 19.5.3, 9.4.2, 9.4.3 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 4/15/26 and 4/16/26, in the presence of the U. S. FOIA (b) (2), it was determined the facility failed to ensure Firefighter's Service is operated monthly with written record for the 3 elevators in accordance with NFPA 101:2012 Edition, Section 19.5.3, 9.4,. 9.4.3, 9.4.3.2 and 9.4.6. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 4/15/26 during a facility tour revealed the facility had 3 operational elevators that served 4 stories and a basement with exit discharge at ground level on 1st floor. Record review of an elevator service pamphlet located in elevator 2 mechanical room revealed the Firefighter's service was performed on elevator # 2 for the months of January, February, March and April 2025, 11 months prior to survey, therefore no Firefighter's service was performed on elevator #2 in the last 11 months. There was no further documentation provided. Elevator # 1 and # 3 had no record Firefighter's service was performed in the last 12 months. In an interview at the time, the U. S. FOIA (b) (2) confirmed the record review and observations. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. N.J.A.C. 8:39 - 31.2(e)(f)	K0531	Continued from page 10 needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	06/21/2026
K0541 SS = F Bldg. 01	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be	K0541	Life Safety K0541- rubbish chutes, incinerators, laundry chutes -laundry room chute will be repaired to latch shut when released from hold open device. -All residents can be affected by deficient practice. -maintenance director or designee will perform an audit monthly, then quarterly to ensure compliance with the laundry chute, to ensure proper latching when released from hold open device. and will be incorporated in logs to show proof that it was done. Administrator or designee will educate the	06/21/2026

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K0541 SS = F Bldg. 01	Continued from page 11 provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 4/15/26, in the presence of the U. S. FOIA (b) (2), it was determined the facility failed to ensure unused laundry chute serving 4 floors and the basement was closed and latched or secured in accordance with NFPA 101: 2012 Edition, Section 19.5.4, 9.5, and NFPA 82: 2009 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 9:55 AM of the laundry room revealed, a laundry chute with the hatch on a hold open device, when tested by releasing, the hatch did not shut and latch. The hatch hit and bounced back remaining open approximately 4 inches. The latching hardware appeared incomplete and was non-functional. The chute was a communication between 5 floor levels (4 stories and a basement). In an interview at the time, the U. S. FOIA (b) (2) confirmed the observation and stated the chute is unused and can be screwed shut. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. N.J.A.C. 8:39 - 31.2(e) NFPA 82	K0541	Continued from page 11 U.S. FOIA (b)(6) to ensure compliance. Education will be completed by 5/22/26. - maintenance director or designee will audit the laundry chute monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	06/21/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for	K0761	Life Safety K0761-maintenance inspection & testing doors -fire door inspection/testing were performed annually, on all fire doors, and documented to show compliance.	06/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315235	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE HEALTH AND REHABILITATION CENTER LLC	325 JERSEY STREET , TRENTON, New Jersey, 08611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0761 SS = F Bldg. 01	Continued from page 12 Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on interview and record review on 4/16/26, in the presence of the U. S. FOIA (b) (2) it was determined the facility failed to ensure: 1. fire door testing was performed annually, and 2. smoke door inspection and testing was performed at least annually, in accordance with NFPA 80: 2010 Edition, and NFPA 105: 2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: Record review of the facility's Life Safety Code Inspection, Testing and Maintenance documents revealed: There were no fire door inspection reports provided for the 22 fire doors observed in the building (all stairway enclosure doors are fire doors). There were no smoke door inspection reports provided for the 8 smoke doors observed in the building. In an interview at the time the U. S. FOIA (b) (2) confirmed the record review. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. N.J.A.C. 8:39 - 31.2(e) NFPA 80, 105	K0761	Continued from page 12 -smoke door inspection/testing were done annually on all doors considered smoke doors. And will be documented to show compliance. -All residents can be affected by deficient practice. -maintenance director or designee started to perform an audit monthly, then quarterly to ensure compliance with all fire and smoke doors, and will be incorporated in logs to show proof that it was done. Administrator or designee will educate the U.S. FOIA (b)(6) to ensure compliance. Education will be completed by 5/22/26. - maintenance director or designee started to audit all fire and smoke doors monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	06/21/2026

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K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation, interview and record review on 4/15/26 and 4/16/26, in the presence of the U. S. FOIA (b) (2) it was determined the facility failed to ensure inspection and testing of non-hospital grade outlets was performed at intervals not exceeding 12 months in accordance with NFPA 99: 2012 Edition, Section 6.3.3, 6.3.3.2.1 to 6.3.3.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations during facility tours on 4/15/26 and 4/16/26 revealed the facility had non-hospital grade outlets at patient bed locations. Record review on 4/16/26 of the facility's Life Safety Code Inspection, Test and Maintenance reports revealed; there were no electrical receptacle inspection and test reports for: physical integrity, polarity, ground continuity and blade tension provided. In an interview at the time the U. S. FOIA (b) (2) confirmed the record review. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM.	K0914	Life Safety K0914-Electrical systems-maintenance and testing -an inspection and testing will be done for all non hospital grade outlets at all patient bed locations as per code. -All residents can be affected by deficient practice. -maintenance director or designee will perform an audit monthly, then quarterly to ensure compliance with inspection and testing of all non hospital grade outlets, and will be incorporated in logs to show proof that it was done. Administrator or designee will educate the U.S. FOIA (b)(6) to ensure compliance. Education will be completed by 5/22/26. - maintenance director or designee will audit all inspections and testing of all non hospital grade outlets monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	06/21/2026

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K0914 SS = F Bldg. 01	Continued from page 14 N.J.A.C. 8:39 - 31.2(e) NFPA 99	K0914		06/21/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on observation, interview and record review on 4/15/26 and 4/16/26 in the presence of the U. S. FOIA (b) (2), it was determined the facility failed to ensure the 2 diesel emergency power generators were Inspected, Tested and Maintained (ITM) in accordance with NFPA 110: 2010 Edition. Sections 8.3, 8.3.3, 8.3.4, 8.4, 8.4.2(1)(2), 8.4.2.3, 8.4.9.1 to 8.4.9.7. This deficient practice had the potential to affect all residents and was evidenced by the following:	K0918	Life Safety K0918- Electrical Systems-Essential Electrical systems maintenance and testing -Two diesel emergency power generators will be tested annually for preventive maintenance and documented. - weekly inspections and tests will be run, and documented weekly. -monthly full load inspections and testing will be done monthly. -3 year, 4 continuous hours full load or 4 hour load bank test will be done to ensure proper working order to meet regulatory compliance. -All residents can be affected by deficient practice. -maintenance director or designee will perform an audit monthly, then quarterly to ensure compliance with all weekly, monthly, annual and 3 year testing/inspecting, and documenting of both generators. and will be incorporated in logs to show proof that it was done. Administrator or designee will educate the U.S. FOIA (b)(6) to ensure compliance. Education will be completed by 5/22/26. - maintenance director or designee will audit all weekly, monthly, annual and 3 year testing/inspecting, and documenting of both generators for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	06/21/2026

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K0918 SS = F Bldg. 01	Continued from page 15 Observations on 4/15/26 during a facility tour revealed there were 2 diesel fueled emergency power generators; Generator #1 is inside and Generator #2 is outside. Record review on 4/16/26 of the emergency generator reports revealed: There was no annual (at least annual) Preventative Maintenance (PM) reports in the last 12 months on either generator #1 and #2 provided. There was no weekly inspection reports for the weekly inspections on either generator #1 and #2 in the last 12 months (52 weeks) provided. There was no monthly full load test reports for the monthly load test on either generator #1 and #2 in the last 12 months provided. There was no 3 year 4 continuous hour full load test or 4 hour load bank test (if the diesel generator runs at less that 30% during its monthly load tests) on either generator #1 and #2 in the last 36 months provided. In an interview at the time, the U. S. FOIA (b) (2) confirmed the record review and stated the U. S. FOIA (b) (2) walked out. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. N.J.A.C. 8:39 - 31.2(e) NFPA 110	K0918		06/21/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a	K0921	Life Safety K0921- electrical equipment testing and maintenance All patient care related electrical equipment will be inspected and documented. A policy will be established and followed to ensure all patient care electrical equipment will have proper inspection and documentation. -All residents can be affected by deficient practice.	06/21/2026

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K0921 SS = F Bldg. 01	Continued from page 16 complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on interview and record review on 4/16/26, in the presence of the U. S. FOIA (b) (2), it was determined the facility failed to ensure Patient Care Related Electrical Equipment (PCREE) was: 1. inspected, tested and maintained based on policies and protocols and a record of electrical equipment tests and repairs is maintained to demonstrate compliance, 2. Policies shall be established for the control of appliances not supplied by the facility in accordance with NFPA 99: 2012 Edition. Sections 10.3, 10.5, 10.5.1, 10.5.2.7 This deficient practice had the potential to affect all residents and was evidenced by the following: Record review of the facility's compliance documents revealed there were no PCREE inspection testing and maintenance reports and no policies and procedures for the control of the equipment not owned by the facility to ensure it is inspected, tested and maintained. In an interview at the time the U. S. FOIA (b) (2) stated that maintenance did the inspections tests and repairs and all electrical equipment that the facility owned and that residents brought in from home. The U. S. FOIA (b) (2) explained that the facility owned the AEDs, air mattresses, and electrical hospital beds and they rent the concentrators. Other equipment identified by the Department of Health, Health and Safety surveyors included: nebulizers, feeding pumps and weight scales. No further documentation was provided. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM.	K0921	Continued from page 16 -maintenance director or designee will perform an audit monthly, then quarterly to ensure compliance with All patient care related electrical equipment , and will be incorporated in logs to show proof that it was done. Administrator or designee will educate the U.S. FOIA (b)(6) to ensure compliance. Education will be completed by 5/22/26. - maintenance director or designee will audit All patient care related electrical equipment monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	06/21/2026

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K0921 SS = F Bldg. 01	Continued from page 17 N.J.A.C. 8:39 - 31.2(e) NFPA 99	K0921		06/21/2026
K0363 SS = E Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and interview on 4/15/26 and 4/16/26, in the presence of the U. S. FOIA (b) (2) it was determined the facility failed to ensure that corridor doors resisted the passage of smoke and positive latched for 10 of 30 doors observed in accordance	K0363	Life Safety K0363-Corridor Doors -The following corridor doors will be adjusted to properly latch. Rooms NJ Ex Order 26, 4B1. -The following doors will be adjusted or repaired to not have a space greater than ½ inch. Rooms NJ Ex Order 26, 4B1 -All residents can be affected by deficient practice. -maintenance director or designee will perform an audit monthly, then quarterly to ensure compliance with all doors not latching or have a gap of space, and will be incorporated in logs to show proof that it was done. Administrator or designee will educate the U.S. FOIA (b)(6) to ensure compliance. . Education will be completed by 5/22/26. - maintenance director or designee will audit all doors not latching or have a gap of space monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance achieved. Administrator or designee is responsible for compliance.	06/21/2026

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K0363 SS = E Bldg. 01	Continued from page 18 with NFPA 101:2012 Edition, Section 19.3.6.3. This deficient practice had the potential to affect 20 of 123 residents and was evidenced by the following: Observations during facility tours on 4/15/26 between 9:24 AM and 12:07 PM and 4/16/26 between 2:57 PM and 3:30 PM revealed: The following corridor doors to resident rooms did not latch when tested NJ Ex Order 26, 4B1 The following corridor doors to resident rooms had spaces between the door and door frame of 1/2 inch or more: NJ Ex Order 26, 4B1 In interviews at the times the U. S. FOIA (b) (2) confirmed the observations. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. N.J.A.C. 8:39 - 31.2(e)	K0363		06/21/2026
K0741 SS = E Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices	K0741	Life Safety K0741-Smoking regulations -proper metal ashtrays will be provided in the smoking area, that meet the regulations. - the garbage can will be removed from the smoking area. The two non metal smoking towers will be removed from the smoking area. -All residents can be affected by deficient practice. -maintenance director or designee will perform an audit monthly, then quarterly to ensure compliance with, proper smoking ashtrays as well as no other garbage bins in smoking area. and will be incorporated in logs to show proof that it was done. Administrator or designee will educate the U.S. FOIA (b)(6) to ensure compliance. Education will be completed by 5/22/26. - maintenance director or designee will audit smoking area ashtrays monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance acheived. Administrator or designee is responsible for	06/21/2026

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K0741 SS = E Bldg. 01	Continued from page 19 into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 4/15/26, in the presence of the [redacted] it was determined the facility failed to ensure ashtrays of noncombustible material and safe design and metal containers with self-closing cover devices into which ashtrays can be emptied were provided in all areas where smoking is permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4(5)(6). This deficient practice had the potential to affect 17 of 123 residents and was evidenced by the following: Observations at 11:10 AM of the designated smoking area located outside the first floor dining room revealed; there was a combustible 32 gallon plastic garbage can with a plastic liner that contained paper and plastic trash and had cigarette butts and ashes mixed in with the combustible trash. There were 2 plastic smoking towers to dispose of cigarette butts. The towers were burned around the top area where the butts were put out on the plastic unit and deposited. There were no ashtrays of noncombustible material and safe design and no metal containers with self-closing cover devices into which ashtrays can be emptied provided. In an interview at the time, the [redacted] confirmed the observations. The facility's [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. This deficient practice was cited at the previous standard survey on 11/25/24. N.J.A.C. 8:39 - 31.2(e)	K0741	Continued from page 19 compliance.	06/21/2026

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RIVERSIDE HEALTH AND REHABILITATION CENTER LLC	**325 JERSEY STREET , TRENTON, New Jersey, 08611**

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E0000	Initial Comments An Emergency Preparedness survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 4/16/26. Riverside Health And Rehabilitation Center was found to be in non-compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Requirements for Long Term Care Facilities.	E0000		05/01/2026
E0006 SS = F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency	E0006	E0006-Plan based on all Hazards risk assessment -emergency plan was updated to include all hazards community and facility based risk assessment and Hazard vulnerability analysis documentation. -All residents can be affected by deficient practice. -maintenance director or designee will perform an audit monthly, then quarterly to ensure compliance with emergency plan to include , all hazards community and facility based risk assessment and Hazard vulnerability analysis documentation. And will update any new risks accordingly. This was incorporated in logs to show proof that it was done. Administrator or designee will educate the U.S. FOIA (b)(6) to ensure compliance. Education will be completed by 5/22/26. - maintenance director or designee will audit compliance with emergency plan, monthly for 3 months. and as needed thereafter to ensure compliance. Maintenance director will report results to quarterly QAPI meetings for 3 months. QAPI team will then determine that compliance is met. Or if needed to continue as appropriate until compliance acheived. Administrator or designee is responsible for compliance.	06/21/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0006 SS = F	Continued from page 1 events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review on 4/16/26, in the presence of the [redacted], it was determined the facility failed to ensure a all hazards community and facility based risk assessment was conducted in accordance with the Code of Federal Regulations CFR 483.73(a)(1)-(2). This deficient practice had the potential to affect all residents and was evidenced by the following: Record review of the facility's Emergency preparedness plan revealed there was no all hazards community and facility based risk assessment or Hazard Vulnerability Analysis (HVA) documentation present to establish, evaluate and review what hazards the facility was susceptible to.	E0006		06/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

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E0006 SS = F	Continued from page 2 In an interview at the time, the U. S. FOIA (b) (2) confirmed the record review. The facility's U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 4/16/26 at 4:12 PM. N.J.A.C. 8:39 - 31.6	E0006		06/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315235	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/17/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 07/17/2026 in relation to the 04/21/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315235	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2026

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